Health Information and Quality Authority
Regulation Directorate

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

Centre name:	Rochestown Nursing Home
Centre ID:	OSV-0000275
Centre address:	Monastery Road, Rochestown, Cork.
Telephone number:	021 484 1707
Email address:	rochestownnursinghome@yahoo.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Brenda O'Brien
Provider Nominee:	Brenda O'Brien
Lead inspector:	Caroline Connelly
Support inspector(s):	Michelle O'Connor
Type of inspection	Unannounced
Number of residents on the date of inspection:	22
Number of vacancies on the date of inspection:	0

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.

Please note the definition of the following term used in reports:
responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

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 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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
25 January 2017 09:45	25 January 2017 19:00

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Major
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Substantially Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Substantially Compliant
Outcome 13: Complaints procedures	Substantially Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This report sets out the findings of an unannounced inspection of Rochestown Nursing Home which is registered to deliver care to 22 residents. This is the fifteenth inspection of the centre by the Health Information and Quality Authority (HIQA). The centre had a history of non-compliance identified during previous inspections in January, June and September 2015. However significant progress and improvements had been seen on the last inspection undertaken in March 2016. Since that inspection HIQA had received a number of concerns in relation to ineffective recruitment and retention of staff in the centre which the inspectors followed up on during the inspection as well as on actions required from the previous inspection. During the inspection the inspectors met with residents, relatives, staff members, the provider, the person in charge, a GP and a speech and language therapist. Inspectors observed practices and reviewed all governance, clinical and operational documentation.

Inspectors found that the premises, fittings and equipment were generally of a good standard, clean and well-maintained. There was a good standard of décor

throughout and well-kept gardens and grounds with plenty of seating available for residents' and relatives' use.

Inspectors found that residents' overall healthcare needs were met and they had access to appropriate medical and allied healthcare services. The quality of residents' lives was enhanced by the provision of a choice of interesting things for them to do during the day. The provider and staff had taken on the role in meeting the social needs of residents and the inspectors observed that staff connected with residents as individuals. The inspector found that residents appeared to be very well cared for. Residents and relatives were spoken with throughout the inspection. The feedback received from them was generally positive and indicated that they were satisfied with the staff and care provided and were particularly satisfied with the variety and quality of activities provided.

A number of significant issues were identified by inspectors during this inspection regarding poor practices in the recruitment of staff, lack of provision of fire training and other mandatory training for staff, poor governance practices and a lack of senior staff. The person in charge of the centre had been on long term leave and only returned to the centre a few months prior to the inspection. During her absence the assistant director of nursing acted up but has now resigned from the centre and had not been replaced to date.

Overall inspectors found the current governance and management of the centre was not effective. Although the provider was generally in the centre on a daily basis there were ineffective systems in place to adequately recruit and ensure staff received mandatory training. There was evidence of a lack of understanding of the regulatory requirements by the provider in relation to many aspects of the running of the centre but particularly in the safe and robust recruitment of staff and in the provision of up-to-date fire and other mandatory training for staff. A sample of staff files were viewed by the inspectors who found that they did not contain all of the information required under Schedule 2 of the Regulations. Recently recruited staff members employed at the centre did not have evidence of Gardai vetting. The provider was made aware this was a major non-compliance and immediately commenced the process of applying for vetting and informed the inspectors staff were to be removed from duties until satisfactory vetting was in place. The inspectors also found that a number of staff files only had one reference and some staff did not have references from the previous employer. Gaps were seen in some CV's and some staff employed by the centre did not have any staff files held for them.

There have been a number of issues with poor recruitment practices and maintenance of staff files identified as non-compliance in previous inspections of the centre and HIQA had issued a notice of proposal to refuse the application for registration renewal in 2016. The provider attended a meeting at HIQA offices and submitted representation to HIQA which outlined the plans to address the areas of non-compliances. At the time the provider demonstrated awareness that lapses in the recruitment process put vulnerable people at risk and highlighted how recruitment practices would be improved. Registration was granted after a follow up inspection where improvements were seen and assurance were received that practices would improve and robust governance structures were put in place. On this

inspection the inspectors found that these assurances had not been actioned and a robust governance structure was not in place. The person in charge was counted as the nurse on duty during the day to care for the 22 residents present at the time of inspection, and did not have the supernumerary time to undertake her managerial and regulatory duties. She was allocated a few hours a week supernumerary time which is not sufficient to undertake her governance and management role. There was no deputy person in charge or senior nurse to assist her in her role and there was limited administrative support available. On this inspection the centre was found to be non-compliant in six of the ten outcomes inspected against, compliant in one outcome and substantially compliant in the other three outcomes. All these issues and other failings are addressed under the relevant outcomes in the body of the report.

A number of other improvements were required to comply with 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. These are dealt with in detail in the Action Plan at the end of this report.

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 Standards for Residential Care Settings for Older People in Ireland.

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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
There was evidence of good consultation with residents. Residents were consulted with on a daily basis. Formal residents' meetings were facilitated. A resident chaired the meetings and maintained minutes of these meetings which were submitted to the person in charge and provider for follow- up, for example, residents suggested menu changes and activity suggestions and residents spoken with confirmed that these were facilitated. An annual review had been completed for 2015 and one was in the process of being completed for 2016.

On the previous inspection inspectors saw that the person in charge had implemented a formal structure to ensure systems and processes were in place to effectively manage and implement an integrated programme of quality and safety. The inspectors saw evidence that this was in place and the quality and safety of care and the quality of life for residents was continually evaluated to determine outcomes for residents regarding the effectiveness of care and support received. This was based on the national standards and in addition, quality data was gathered on a weekly basis (pain, pressure sores, physical restraint, psychotropic medication, falls, indwelling catheters, significant weight loss, complaints, unexplained absences, significant events, vaccinations and immobile residents). This data was trended to inform practice. Other clinical audits were demonstrated to ensure suitable and safe care, for example, hand hygiene and environmental hygiene. These reports formed the basis for the monthly 'Quality Management Systems Improvement meetings' attended by the provider and the person in charge. On this inspection the inspectors saw that since the person in charge went on leave a lot of these systems had not continued and the quality improvement meeting had not taken place. Staff meetings had also not taken place during this time. The inspectors saw that the person in charge had recommenced the collection of data and recommenced the audit process. The provider assured the inspectors the governance

meetings would recommence.

Overall inspectors found the current governance and management of the centre was ineffective. Although the provider was generally in the centre on a daily basis there were ineffective systems in place to adequately recruit and ensure staff received mandatory training. There was evidence of a lack of understanding of the regulatory requirements by the provider in relation to many aspects of the running of the centre but particularly in the safe and robust recruitment of staff and in the provision of up-to-date fire and other mandatory training for staff. This has left vulnerable residents at risk. A sample of staff files were viewed by the inspectors who found that they did not contain all of the information required under Schedule 2 of the Regulations. Recently recruited staff members including maintenance personnel employed by the centre did not have evidence of Gardai vetting. The provider was made aware this was a major non-compliance and she immediately commenced the process of applying for and chasing up vetting and informed the inspectors she was removing staff from duties until satisfactory vetting was in place. The inspectors also found that a number of staff files only had one reference and some staff did not have references from the previous employer. Gaps were seen in some CV's and the maintenance staff employed by the centre did not even have any staff files.

There have been issues with poor recruitment practices and maintenance of staff files identified as non-compliance in numerous other inspections of the centre and HIQA had issued a notice of proposal to refuse the application for registration renewal in 2016. The provider attended a meeting at HIQA offices and submitted representation to HIQA which outlined the plans to address the areas of non-compliances. At the time the provider demonstrated awareness that lapses in the recruitment process put vulnerable people at risk and highlighted how she would improve recruitment practices. Registration was granted but only after a follow up inspection where improvements were seen and assurance that practices would improve and robust governance structures were put in place. On this inspection the inspectors found that these assurances had not been actioned and a robust governance structure was not in place. The person in charge was counted as the nurse on duty during the day to care for the 22 residents present at the time of inspection, and did not have the supernumerary time to undertake her managerial and regulatory duties. She was allocated a few hours a week supernumerary time which is not sufficient to undertake her governance and management role. There was no deputy person in charge or senior nurse to assist her in her role and there was limited administrative support available. That also meant there was no senior nurse who could take charge of the centre in the absence of the person in charge.

There was evidence of poor compliance with regulatory requirements in that the centre was found to be non-compliant in six of the ten outcomes inspected against, compliant in one outcome and substantially compliant in the other three outcomes. Overall the governance of the centre required immediate review and action.

Judgment:
Non Compliant - Major

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 has been in post since May 2015. She is a full time registered nurse, with the required experience of nursing dependant people (as detailed in the regulations). She demonstrated good knowledge and understanding of the regulations and the National Standards to inform care and welfare and this was evidenced through the interview conducted as well as the quality initiatives she commenced since taking up the post.

She was proactive in her own professional development, for example she had completed education to enable her to train staff in adult protection, manual handling and lifting and hand hygiene. She organised the yearly training schedule for staff with the centre manager. She was instrumental in ensuring that all staff had read and understood the policies which she updated since her arrival.
As discussed under outcome 2 she had put managerial and quality systems in place.

Staff, residents and relatives identified her as the one with the overall responsibility and accountability for residents' care.

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):
Some action(s) required from the previous inspection were not satisfactorily

implemented.

Findings:
Residents' records were reviewed by inspectors who found that they complied with Schedule 3 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. The records listed in Schedule 4 to be kept in a designated centre were all maintained and made available to the inspector.

The designated centre had recently updated and implemented 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 and these are reviewed and updated at intervals not exceeding three years as required by Regulation 4. Inspectors viewed the insurance policy and saw that the centre is adequately insured against accidents or injury to residents, staff and visitors.

A sample of staff files were viewed by the inspectors and found that they did not contain all of the information required under Schedule 2 of the Regulations. Recently recruited staff members including maintenance personnel employed by the centre did not have evidence of Gardai vetting. The National Vetting Bureau (Children and Vulnerable Persons) Act 2012 has set out that registered providers of designated centres are required to ensure that no person recruited on or after 29 April 2016 (whether on a part-time, full-time, volunteer or other basis) is allowed to work at, or be involved with, the designated centre unless the registered provider has sought and received a vetting disclosure from the National Vetting Bureau of An Garda Síochána. The provider was made aware this was a major non-compliance and she immediately commenced the process of applying for vetting and informed the inspectors she was removing staff from duties until satisfactory vetting was in place. The inspectors saw that a number of staff files only had one reference and some staff did not have references from the previous employer. Gaps were seen in some CV's and the maintenance staff employed by the centre did not have any staff files. There have been issues with recruitment and maintenance of staff files identified as non-compliant in numerous other inspections in the centre and this is discussed under outcome 2 Governance.

Judgment:
Non Compliant - Major

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:
Measures were in place to protect residents from being harmed or suffering abuse. There was an up-to-date policy for adult protection. Inspectors reviewed staff training records and saw evidence that most staff had received up to date mandatory training on detection and prevention of elder abuse. However, there were new staff employed that did not have training and were required to attend same. Staff interviewed were familiar with the policy and knew what to do in the event of an allegation, suspicion or disclosure of abuse, including whom to report incidents to. The person in charge was aware of her legal obligations to report issues. She adequately described protection of residents as well as actions to be taken if an allegation was made.

Systems were in place to safeguard resident’s money. The registered provider demonstrated to the inspectors how resident funds and transactions were recorded, and the system in place to verify that amounts were correct. Residents had individual safes in their bedrooms to keep their valuables and most residents were responsible for their own finances. There were receipt books available for chiropody and hairdressing demonstrating residents' receipt of these services, but individual receipts would make the system more transparent which the provider said she would put in place at the last inspection but this was still not in place for the hairdresser on this inspection. The provider was a pension agent for a number of residents and a sample of records viewed indicated adequate records of financial transactions. However these residents did not have personal bank accounts and inspectors saw that sums of money were being held within the nursing home account for a number of residents and not in a separate resident account. This system did not facilitate residents to accumulate interest on their savings and their finances were not fully protected. The provider reassured inspectors that this would addressed.

A policy on managing responsive behaviours was in place. The inspectors saw training records and although a number of staff had undertaken training there was not evidence that all staff had received training in responsive behaviours. There was evidence that efforts were made to identify and alleviate the underlying causes of behaviour that posed a challenge. The support of the community psychiatry service was availed of as appropriate to residents needs as further outlined under Outcome 11. From discussion with the person in charge and staff and observations of inspectors there was evidence that residents who presented with responsive behaviours were responded to by staff in a very dignified and person-centred way using effective de-escalation methods. However these were not detailed in responsive behaviour care plans, which are required to direct care and to ensure a consistent approach to responsive behaviours is undertaken by all staff. This is particularly relevant to guide new staff. The action for this is under outcome 11.

There was a centre-specific restraint policy dated February 2016 which aimed for a restraint free environment and included a direction for staff to consider all other options prior to its use. The inspectors saw that the centre was operated as a restraint free centre and no bed-rails or other physical restraints were in use at the time of inspection and had not been used in the centre for a number of years.

Judgment:
Non Compliant - Moderate

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 health and safety statement seen by inspectors was centre-specific and dated January 2016. The risk management policy was found to be comprehensive and included all the requirements of Regulation 26(1). The risk register was up to date and it identified and outlined the management of clinical and environmental risks. Clinical risk assessments were undertaken, including assessments for dependency, risk of pressure sore formation, falls risk assessments and monitoring of weight.

There was a centre-specific emergency plan that took into account a number of potential emergency situations and where residents could be relocated to in the event of being unable to return to the centre. The provider has contracts in place for the regular servicing of all equipment and inspectors viewed records of equipment serviced which were all up-to-date.

The fire safety policy was centre-specific. There were fire safety notices throughout the building for residents and staff, including signs on doors and evacuation plans on the walls. Inspectors saw records that fire fighting alarm system was checked weekly. All fire door exits observed were unobstructed. Fire fighting and safety equipment had been tested in January 2016 and the fire alarm and emergency lighting were last serviced on 30 September 2016 and were found to be overdue their quarterly service .
The provider told inspectors and records showed that a number of fire drills had taken place in 2016. However, the actions taken and outcome of the fire drills were not documented; therefore there was no record of learning from the drill and improvements required as a result. There was evidence that fire training had not been provided to staff in 2016 and some staff interviewed by inspectors, were unclear how to respond in the event fire and had not received training for a number of years. The provider was informed at the feedback that this required immediate action to ensure all staff had up to date fire training. Training records viewed by the inspectors also indicated that some staff had not received up to date moving and handling training as is required by the regulations, the action for this is under outcome 18 Staffing.

There was generally evidence of good practice with regard to infection prevention and control. An up-to-date infection control policy was in place. Alcohol hand rub was readily available throughout the centre and there were notices with regard to hand washing at

sinks. Laundry which was being cleaned in-house was separated in line with best practice. Records indicated that staff had been trained in infection control and hand hygiene and inspectors observed staff using opportunities to use the hand sanitisers throughout the inspection.

Judgment:
Non Compliant - Moderate

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:
The medication trolley was secured and the medication keys were held by the nurse in charge. Medications were stored and disposed of appropriately in line with An Bord Altranais and Cnáimhseachais na hÉireann Guidance to Nurses and Midwives on Medication Management (2007). Controlled drugs were stored in accordance to best practice guidelines and nurses were checking the quantity of medications at the start of each shift. The inspector did a count of controlled medications with the nurse which accorded with the documented records.

There were written operational policies advising on the ordering, prescribing, storing and administration of medicines to residents. Inspectors reviewed a number of medication prescription charts and noted that all included the resident's photo, date of birth, general practitioner (GP) and details of any allergy. Prescription and administration records contained appropriate identifying information and were clear and legible. However medications that required crushing were not seen to be prescribed as such for each individual medication that required crushing, therefore nursing staff were administering medication to residents in crushed format although it had not been specifically indicated on the prescription sheet and there was no list available of medications that cannot be crushed maintained. As required medications stated frequency of dose therefore ensuring there was a maximum dose in 24 hours that could not be exceeded.

There was evidence on the medication prescription sheets of regular review of medications by the GP's. Medication errors were recorded and there was evidence that appropriate action was taken as a result of same. Nursing staff undertook regular updates in medication management training as evidenced by training records. Medications were supplied and administered from a monitored dosage system and there were references and photos readily available for the nurse to confirm prescribed medication in the compliance aid as is required by An Bord Altranais and

Cnáimhseachais na hÉireann Guidance to Nurses and Midwives on Medication Management (2007). In the event of needing to withhold or replace a medication that was dropped.

Judgment:
Substantially Compliant

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.

Theme:
Effective care and support

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

Findings:
Residents had a choice of General Practitioner (GP) and some residents continued to have their medical care needs met by their GP prior to their admission to the centre. The inspectors met one of the GPs visiting his residents during the inspection. Residents also had access to allied healthcare professionals including physiotherapy, occupational therapy, dietetic, speech and language therapy, dental, podiatry and ophthalmology services. The inspectors also meet the speech and language therapist who was assessing a resident and prescribing an updated plan for them. She confirmed that she receives appropriate referrals from the centre and that staff implement the residents prescribed plans of care. Physiotherapy was provided in house as required and paid for privately. Occupational therapy services were available through the local community. Residents in the centre also had access to the specialist mental health of later life services who provided services to review and follow up residents with mental health needs and residents who displayed behavioural symptoms of dementia. Community nurses visited the residents on a regular basis providing advice support and ongoing review.

Inspectors saw that residents had a comprehensive nursing assessment completed on admission. The assessment process involved the use of a variety of validated tools to assess each resident's risk of deterioration. For example, risk of malnutrition, falls, level of cognitive impairment and pressure related skin injury among others. Pain charts in use reflected appropriate pain management procedures. Each resident had a care plan developed within 48 hours of their admission based on their assessed needs. However the inspectors saw that the assessment documentation appeared cumbersome with excess documentation and a streamlining of the process would facilitate more concentration on the care planning process. There were care plans in place that detailed

the interventions necessary by staff to meet residents' assessed healthcare needs. They generally contained the required information to guide the care and were regularly reviewed and updated to reflect residents' changing needs and were person centred and individualised. However there was not a specific detailed plan put in place to guide care for residents with responsive behaviours as was outlined in outcome 7 Safeguarding.

Nursing staff and health care assistants spoken with were familiar with and knowledgeable regarding residents up to date needs. Inspectors saw that there were suitable arrangements in place to meet the health and nursing needs of residents with dementia. Residents and their families, where appropriate were involved in the care planning process, including end of life care plans which reflected the wishes of residents.

Residents at risk of developing pressure ulcers had care plans and pressure relieving mattresses and cushions to prevent ulcers developing. Nursing staff advised the inspector that there were no residents with pressure sores or major wounds in the centre at the time of inspection but they had a number of residents who were very prone to pressure sore formation and appropriate measures were seen to be in place for those residents. Staff had access to support from the tissue viability nurse as required.

Judgment:
Non Compliant - Moderate

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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
The design and layout of the centre fitted with the aims and objectives set out in the statement of purpose. The premises could accommodate a maximum of 22 residents and provided adequate communal and private space for the residents living there. On the previous inspection it was identified that twin bedroom number 10 had very limited space to accommodate two residents. Conditions attached to the registration certificate for this centre outlined that when one resident vacated room 10, then that room will be converted to single occupancy. On this inspection the inspectors saw that this room was now single occupancy. However the provider was having the room extended so that it could comfortable accommodate two residents and to ensure the privacy and dignity of

residents could be maintained. The provider is to apply for a variation to the conditions of registration to accommodate another resident in that room.

There had been an ongoing programme of maintenance and painting of the centre. The centre and the grounds overall were noted to be clean and in a good state of repair and décor. On the previous inspections it was noted that the showers in bedrooms 7 and 8 had been removed leaving just a toilet and wash-hand basin in the two en-suites. On this inspection the inspectors saw that a new assisted shower had been installed and the residents were very happy with same. The provider said she planned to do the same in room 7 providing extra shower facilities for the residents living there.

The inspectors saw evidence of the use of assistive devices, for example, hoists, wheelchairs, walking aids, clinical monitoring equipment and specialist seating provided for residents' use. And up-to-date service record was in place. There was a functioning call-bell system in place. However a curtain was noted to be torn in one of the bedrooms and one of the pressure relieving cushions was noted to be torn and worn and required repair or replacement.

The external courtyard was well maintained and residents stated they enjoyed this during the summer. This space was partially covered and provided a safe outdoor space.

Judgment:
Substantially Compliant

Outcome 13: Complaints procedures
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.

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 there was a complaints process in place to ensure the complaints of residents, their families or next of kin including those with dementia were listened to and acted upon. The process included an appeals procedure. The complaints procedure was prominently displayed in the centre. However the policy differentiated between verbal and complaints of a significant nature, directing that verbal complaints to be just documented in residents records. This is contrary to the requirements of legislation which states that complaints are properly recorded and that such records are in addition to and distinct from a resident's individual care plan. The actual practice in the centre is that all complaints are logged in the complaints log. The inspector viewed the complaints log and saw that complaints, actions taken and outcomes were documented in accordance with best practice and that feedback is given to the complainant. However

the inspector did note there were no complaints logged for 2016.

Residents and relatives said that they had easy access to the person in charge who was identified as the named complaints officer to whom they could openly report any concerns and were assured issues would be dealt with. The person in charge stated that she monitored complaints or any issues raised by being readily available and regularly speaking to residents, visitors and staff. Records showed that complaints made to date were dealt with promptly and the outcome and satisfaction of the complainant was recorded.

There was an independent appeals person nominated and the policy had been updated to include the facility to refer to the Ombudsman if required.

Judgment:
Substantially 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.

Theme:
Workforce

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Residents and relatives spoke positively of staff and indicated that staff were caring, responsive to their needs and treated them with respect and dignity. This was seen by the inspectors throughout the inspection in the dignified and caring manner in which staff interacted and responded to the residents. Residents told the inspectors that they could identify issues to the person in charge if they had any concerns. They spoke about the full and varied programme of activities that went on in the centre and their enjoyment of same.
Systems of communication were in place to support staff with providing safe and appropriate care. There were handover meetings each day to ensure good communication and continuity of care from one shift to the next. In discussions with staff, they confirmed that they were supported to carry out their work by the person in charge. The inspector found staff to be well informed and knowledgeable regarding their roles, responsibilities and the residents' needs and life histories. There was evidence that

residents knew staff well and engaged easily with them in personal conversations.

Training records viewed by the inspectors confirmed the provision of ongoing professional development training. However mandatory training was not in place for fire safety, some staff did not have protection of vulnerable adults, responsive behaviours training and resident moving and handling. The actions for these are detailed under outcome 7 and 8. As identified on the previous inspection it was difficult to establish what training was due for renewal or updating as there was not a comprehensive training matrix in place showing when all staff last had the training. The provider assured inspectors this would be put in place following the last inspection but the inspectors saw on this inspection it had been commenced but was not continued and kept up to date.

The human resource policy was centre-specific and included details for the recruitment, selection and vetting of staff. However as discussed under outcomes 2 and 5 the inspectors had serious concerns in relation to recruitment practices in the centre particularly in relation to staff files and the lack of evidence of Gardaí vetting for a number of staff as outlined in outcome 5.

Inspectors reviewed staffing rotas, staffing levels and skill mix and were generally satisfied that there were sufficient staff on duty during the day to meet the needs of the current residents. However the inspectors requested that the provider keep the staffing levels under review particularly in the evening and at night time when staffing levels reduce substantially.

Judgment:
Non Compliant - Moderate

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:

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Regulation Directorate
Health Information and Quality Authority

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Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Rochestown Nursing Home
Centre ID:	OSV-0000275
Date of inspection:	25/01/2017
Date of response:	03/03/2017

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 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The person in charge was counted as the nurse on duty during the day to care for the 22 residents present at the time of inspection, and did not have the supernumerary time to undertake her managerial and regulatory duties. She was allocated a few hours a week supernumerary time which is not sufficient to undertake her governance and management role. There was no deputy person in charge or senior nurse to assist her in her role and there was limited administrative support available. That also meant

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

there was no senior nurse who could take charge of the centre in the absence of the person in charge.

1. Action Required:
Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
We are actively trying to recruit a new deputy nurse in charge and have interviewed candidate for position as well as dealing with different agencies for nurse that fits criteria required. Candidates suitability been assessed from what CV's agencies have sent us.
The person in charge has set out her own supernumerary hours on off duty as she requires them.

Proposed Timescale: Ongoing

Proposed Timescale: 03/03/2017

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Overall inspectors found the current governance and management of the centre was ineffective. There were ineffective systems in place to safely recruit staff and to ensure staff received mandatory training. There was evidence of a lack of understanding of the regulatory requirements by the provider in relation to many aspects of the running of the centre but particularly in the safe and robust recruitment of staff and in the provision of up-to-date fire training for staff.

2. Action Required:
Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
Recruitment of staff is an important issue and we will only recruit staff who are fit to work at nursing home and as provider along with the person in charge will follow our policy to recruit staff who have qualifications suitable to the work that they are due to perform with the skills & experience necessary along with the mandatory training needed. The nursing home provides onsite mandatory training . Some onsite training is being done by our qualified person in charge and current schedule is as follows. Elder abuse on the 27/03/17, Behaviour that challenges on 17/04/17, Infection control on 08/05/17. Other training scheduled includes Manual Handling on 24/03/17 and Fire training on 21/03/17. Courses organised outside nursing home as well when required. I the provider along with the person in charge will ensure all staff have up to date

training and will follow policy & standards for staff recruitment

Proposed Timescale: Ongoing

Proposed Timescale: 03/03/2017

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:
A sample of staff files were viewed by the inspectors and found that they did not contain all of the information required under Schedule 2 of the Regulations. Recently recruited staff members including maintenance personnel employed by the centre did not have evidence of Gardai vetting. Gaps were seen in some CV's and the maintenance staff employed by the centre did not have any staff files. The inspectors saw that a number of staff files only had one reference and some staff did not have references from the previous employer.

3. 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:
Garda Vetting has been completed for 5 staff since inspection. Maintenance staff now have their own staff file. Cv's updated to eliminate any gaps in employment. Reference requests sent for staff who are part time and those who require from most recent employer. All verified when in receipt of same.

Proposed Timescale: 17/03/2017

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had up to date training, knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

4. Action Required:
Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour

that is challenging.

Please state the actions you have taken or are planning to take:
Up to date training matrix done and dates informed to staff. Handout information/ Careplan – specific to residents who are challenging behaviour done and informed too all staff and left on office notice board. Staff have read and signed for same.

Proposed Timescale: 10/03/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider was a pension agent for a number of residents and a sample of records viewed indicated adequate records of financial transactions. However these residents did not have personal bank accounts and inspectors saw that sums of money were being held within the nursing home account for a number of residents. This system did not facilitate residents to accumulate interest on their savings and their finances were not fully protected. Individual receipts were not available for hairdressing.

5. Action Required:
Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

Please state the actions you have taken or are planning to take:
Hairdresser submitting receipts on next visit on 14/03/17 and is to furnish nursing home with receipt after every appointment. We are currently reviewing our system and policy with regards residents finances. We have sought advice from our business bank the Bank of Ireland and from An Post who deal with the residents pensions. We are awaiting feedback and guidance as to what steps can be taken in relation to residents accounts and what is required to do so.

Proposed Timescale: Ongoing

Proposed Timescale: 03/03/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all staff had up to date training in safeguarding and protection of residents

6. Action Required:
Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

Please state the actions you have taken or are planning to take:
Training for protection and safeguarding of residents arranged on site for staff

Proposed Timescale: 10/04/2017

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The fire alarm and emergency lighting were last serviced on 30 September 2016 and were found to be overdue their quarterly service

7. Action Required:
Under Regulation 28(1)(c)(i) you are required to: Make adequate arrangements for maintaining all fire equipment, means of escape, building fabric and building services.

Please state the actions you have taken or are planning to take:
Quarterly service took place on 11th of December 2016 but had been filled in 11/09/16 as previous quarterly service had been done on the 30/09/16. We informed the service crew of this error and they have come out and checked everything and filled out correct date on new documentation. Next service is due March 2017.

Proposed Timescale: Completed

Proposed Timescale: 03/03/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all staff had up to date fire training and some staff spoken to were unclear what to do in the event of a fire.

Although fire drills took place the outcome of the fire drills were not documented; therefore there was no record of learning from the drill and improvements required as a result.

8. Action Required:
Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques

and the procedures to be followed should the clothes of a resident catch fire.

Please state the actions you have taken or are planning to take:
Training arranged for staff to receive suitable training in fire prevention & emergency procedures, including evacuation procedures, building layout escape routes, location of fire alarm call point, fire zones, first aid, etc. Fire training done on 27/01/17, and on the 23/02/2017, and further training session booked for the 21st of March with Argos fire & safety ltd. We have documented last fire drill and evacuation procedure which was done during learning session on the 23/02/17. As per policy 2 fire drill evacuations done annually along with other training. Fire drill document kept in nurse's station for future reference and to make further improvements in the future following daily and weekly checks which are done along with the monthly and quarterly checks. Fire drill evacuation plan also kept in nurses station which includes each resident and their nearest exit and method of evacuation used in the event of a fire. Evidence of training been sent for your attention.

Proposed Timescale: Ongoing

Proposed Timescale: 03/03/2017

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:
Medications that required crushing were not seen to be prescribed as such for each individual medication that required crushing, therefore nursing staff were administering medication to residents in crushed format although it had not been specifically indicated on the prescription sheet and there was no list available of medications that cannot be crushed maintained.

9. 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:
We currently have 4 residents on crushed medications and requested GP to write in medication cardex against each medication that can be crushed. It is double checked by pharmacist and if the particular tablet that has been requested to be crushed by GP can't be crushed, then this means pharmacist requests or gives suggestion to GP for alternative tablet in the same group of medication. In addition to that medication administration chart- Highlighted for crushed medications for easy recognition by nurses. This is reviewed monthly. Audit also done by pharmacist & nurse and signed for same.

Proposed Timescale: 27/03/2017

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was not a specific plan put in place to guide care for residents with responsive behaviours to ensure all staff maintained a consistent approach.

10. Action Required:
Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

Please state the actions you have taken or are planning to take:
Guide for responsive behaviour action done & documented. This has been displayed in nurses station and all staff sign for same.

Proposed Timescale: Completed

Proposed Timescale: 03/03/2017

Outcome 12: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A curtain was noted to be torn in one of the bedrooms and one of the pressure relieving cushions was noted to be torn and worn and required repair or replacement.

11. Action Required:
Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

Please state the actions you have taken or are planning to take:
Replaced

Proposed Timescale: Completed

Proposed Timescale: 03/03/2017

Outcome 13: Complaints procedures
Theme: Person-centred care and support **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** The complaints policy differentiated between verbal and complaints of a significant nature, directing that verbal complaints to be just documented in residents records. This is contrary to the requirements of legislation which states that complaints are properly recorded and that such records are in addition to and distinct from a resident's individual care plan. **12. Action Required:** Under Regulation 34(2) you are required to: Fully and properly record all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are and ensure such records are in addition to and distinct from a resident's individual care plan. **Please state the actions you have taken or are planning to take:** Policy updated to reflect recording of all complaints including verbal in the complaint register and any actions and investigations associated with it as well as the individual resident's careplan. Proposed Timescale: Completed
Proposed Timescale: 03/03/2017

Outcome 18: Suitable Staffing
Theme: Workforce **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** All staff had not received mandatory training including training in moving and handling, and due to lack of appropriate records of staff training such as a training matrix as required from the last inspection it was difficult to establish when training took place and when it was due for renewal. **13. Action Required:** Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training. **Please state the actions you have taken or are planning to take:** New training matrix has been completed and training is scheduled for healthcare staff

as per the requirements. Proposed Timescale: Ongoing
Proposed Timescale: 03/03/2017