<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Rochestown Nursing Home</th>
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</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000275</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Monastery Road, Rochestown, Cork.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>021 484 1707</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:rochestownnursinghome@yahoo.ie">rochestownnursinghome@yahoo.ie</a></td>
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<tr>
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<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Brenda O'Brien</td>
</tr>
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<td>Provider Nominee:</td>
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<tr>
<td>Lead inspector:</td>
<td>Caroline Connelly</td>
</tr>
<tr>
<td>Support inspector(s):</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.

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).
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: 17 October 2017 11:00  
To: 17 October 2017 18:45

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

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<thead>
<tr>
<th>Outcome</th>
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<tr>
<td>Outcome 02: Governance and Management</td>
<td>Non Compliant - Major</td>
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<td>Outcome 03: Information for residents</td>
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<td>Outcome 05: Documentation to be kept at a designated centre</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 13: Complaints procedures</td>
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<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Non Compliant - Moderate</td>
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**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 eighteenth 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 and although significant progress and improvements had been seen on an inspection undertaken in March 2016, inspections in January and July 2017 again identified high levels of non-compliance. Governance and management of the centre and ineffective recruitment and retention of staff were some of the key non-compliances identified. Because of evidence of on-going and persistent non compliances noted on the previous inspection, two further restrictive conditions were attached to the registration of the centre, one which outlined that no new residents were to be admitted to the centre which came into effect on the 15 June 2017. During the inspection in July the inspectors saw that the condition which directed the registered provider not to accept any further admissions to the designated centre had been breached. Following this there had been substantial engagement with the provider by HIQA and a substantial governance and management plan was forwarded to HIQA to address areas of non-compliance.

Since the previous inspection the provider had employed a Governance Manager to
monitor and review the quality and safety of care and services. The governance manager commenced employment in August 2017. There was also a new person in charge who commenced employment in the centre on the 25 September 2017. This person in charge was supernumerary to the nursing compliment and there was always a nurse on duty in addition to the person in charge. The provider was also in the centre on a daily basis and took over the role of co-ordinating the activities. Management meetings had recommenced and audits were taking place.

The inspectors arrived to the centre at 11.00hrs to find that the centre did not have any electricity. The power had been cut the previous day around 13.00hrs due to extreme weather conditions. The provider had been in constant contact with the power network trying to establish when power would be restored however this information was not available at that time but did become available at 14.00hrs when the provider was informed it would not be back until the next day. The provider did not have a generator to maintain essential services in the centre and at the commencement of the inspection had not tried to source a generator. The inspectors insisted that a generator was required to maintain essential services and one should have been available as soon as the power went out to ensure the safety and comfort of the residents. Following the opening meeting the provider went to source a generator, this was eventually sourced and was about to be installed when the power was returned at 19.45hrs. This lack of emergency planning is discussed in more detail in the report under health and safety.

During this inspection, the inspectors met with residents, staff members, the provider, the new person in charge and relatives. Inspectors observed practices and reviewed all governance, clinical and operational documentation. Inspectors found that the premises, fittings and equipment were generally of a reasonable 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. Residents were consulted about the running of the centre and feedback was sought to inform practice. Residents’ meetings were held regularly to allow residents the opportunity voice any concerns. Customer feedback questionnaires were available at reception.

Despite the lack of electricity residents were engaged in a number of activities during the inspection including group games and newspaper reading. The centre had a gas hob so hot food and drinks were available for the residents. Residents with whom inspectors spoke were very happy with the level of activities and said there was always plenty of entertainment. Residents said that when there was no electricity the previous night the staff commenced a sing song which distracted from the lack of electricity. The residents said most residents participated in the sing song and it distracted them from the lack of power. Inspectors found that residents’ overall healthcare needs were met and they had access to appropriate medical and allied healthcare services. The inspectors found that residents appeared to be very well cared for. The feedback from residents and relatives was generally positive and indicated that they were satisfied with the staff and care provided.

A number of significant issues were identified by inspectors during the previous inspections in January 2017, 05 July 2017 and 21 July 2017 regarding unsatisfactory
practices in the recruitment of staff, lack of provision of mandatory training for staff, poor governance and a lack of senior staff. On this inspection staff files were again checked for all staff working in the centre. Inspectors found that recruitment practices continued to be unsafe. The inspectors identified gaps in vetting procedures, with one staff working at the centre without appropriate vetting and a number of staff without references being attained for them. This included the recently recruited person in charge where the provider had not secured references from her previous employers. Gaps were seen in CV's and there was a lack of a CV for one staff. Although staff files were commenced for part time staff these files did not contain all the requirements of schedule 2. The administrator continued to not have any staff file despite this being highlighted at previous inspections. The provider was made aware again that this was a major non-compliance and that lapses in the recruitment process could put vulnerable people at risk. Following the previous inspections and in the governance plan submitted to HIQA, the inspectors were given assurances that issues with recruitment would all be prioritized and rectified. However inspectors found that although some improvements in staff files were seen, further staff had been employed without all of the appropriate vetting or checks taking place.

There had been an emphasis on staff training since the previous inspection and the majority of staff had received mandatory staff training however there continued to be a number of part time staff who had not received fire training for the centre nor had they been present for a fire drill which is a high risk if they were the second staff on duty particularly at night. A training matrix was made available to the inspectors which the provider had updated. This matrix continued to identify gaps in the provision of safeguarding to the administrator who deals with resident's finances and maintenance staff. A number of staff were also missing responsive behaviours training.

On this inspection, the centre was found to be non-compliant in three of the seven outcomes inspected against, three of these outcomes at major non-compliance, one at moderate non-compliance, two substantially compliant and compliance in the other outcome. All these issues and other failings are addressed under the relevant outcomes in the body of the report. 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. Because of evidence of on-going and persistent non compliances the two restrictive conditions remain attached to the registration of the centre, including the one which outlined that no new residents were to be admitted to the centre which came into effect on the 15 June 2017.

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 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:
The centre had a history of non-compliance identified during previous inspections in January, June and September 2015 and although significant progress and improvements had been seen on an inspection undertaken in March 2016, inspections in January 2017 and July 2017 again identified high levels of non-compliance. Governance and management of the centre and ineffective recruitment and retention of staff were some of the key non-compliances identified. Because of evidence of on-going and persistent non compliances noted on the inspection in January 2017, two further restrictive conditions were attached to the registration of the centre, one which outlined that no new residents were to be admitted to the centre which came into effect on the 15 June 2017. During the inspection of the 05 July 2017, the inspectors saw that the condition which directed the registered provider not to accept any further admissions to the designated centre had been breached.

On a number of these previous inspections, the inspectors found the governance and management of the centre was ineffective. 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. There was not a clearly defined management structure and the person in charge had limited supernumerary time to undertake her managerial responsibilities. The provider attended a series of meetings in the HIQA office and furnished HIQA with a comprehensive Governance and Management plan for the centre.

Since the previous inspections in July 2017, the provider had employed a Governance Manager to monitor and review the quality and safety of care and services. The governance manager commenced employment in August 2017. There was also a new person in charge who commenced employment in the centre on the 25 September 2017. This person in charge was supernumerary to the nursing compliment and there was
always a nurse on duty in addition to the person in charge. The provider was also working in the centre on a daily basis and took over the role of co-ordinating the activities. Management meetings had recommenced, however, the minutes of the meeting held the week prior to the inspection were not available for the inspectors to view. Minutes of previous meetings were seen and a number of unresolved issues appeared to be consistent since July 2017. These unresolved issues included having a staff meeting and commencing staff appraisals. Staff confirmed that there had not been a full staff meeting in the centre during 2017. The person in charge said they had a meeting planned for this week and she had planned to discuss and hand out staff appraisal forms during this meeting. Although there was a more robust governance structure evident with roles and responsibilities outlined in the governance plan submitted to HIQA, this plan outlines the role of deputy person in charge. Currently this role has not been filled and there was no deputy to take on the person in charge role in the absence of the person in charge.

The inspectors saw that the new person in charge had continued with the formal structure that was in place which was based on national standards where quality data was gathered on a weekly basis (pain, pressure sores, physical restraint, psychotropic medication, and falls, indwelling catheters, significant weight loss, complaints, unexplained absences, significant events, vaccinations and immobile residents). There was evidence of further auditing taking place by the governance manager into clinical aspects of care and care planning. The provider assured the inspectors that staff files had been audited to ensure they were compliant with schedule 2 of the Care and Welfare in Designated Centres for Older People) Regulations 2016 (as amended). However, inspectors found significant gaps in staff files. Inspectors found that recruitment practices continued to be unsafe. The inspectors identified gaps in vetting procedures, with one staff working at the centre without appropriate vetting and a number of staff without references being attained for them. This included the recently recruited person in charge where the provider had not secured references from her previous employers. Gaps were seen in CV’s and there was no CV for one staff. Although staff files were commenced for part time staff, these files did not contain all the requirements of schedule 2. The administrator continued to not have any staff file despite this being highlighted at previous inspections. The provider was made aware again that this was a major non-compliance and that lapses in the recruitment process put vulnerable people at risk. Following the previous inspections and in the governance plan submitted to HIQA, the inspectors were given assurances that issues with recruitment would all be prioritised and rectified. However, inspectors found that although some improvements in staff files were seen, further staff had been employed without all of the appropriate vetting or checks taking place.

The inspectors were not satisfied that there was sufficient planning in place for emergency situations in that no contingencies were put into place for the loss of power which affected all aspects of the running of the centre and the safety of residents and staff. This will be discussed further under Outcome 8 Health and Safety.

Overall the inspectors were not satisfied that the current governance arrangements were sufficiently robust, this was evidenced by poor recruitment practices, lack of emergency planning, lack of progress on the governance and management plan submitted to HIQA and continued levels of non-compliance in the centre, On this
inspection, the centre was found to be non-compliant in four of the seven outcomes inspected against, three of these outcomes at major non-compliance, one at moderate non-compliance and substantial compliance in two outcomes and compliance in one outcome. Because of evidence of on-going and persistent non compliances, the two restrictive conditions remain attached to the registration of the centre, including the one which outlined that no new residents were to be admitted to the centre which came into effect on the 15 June 2017.

Judgment:  
Non Compliant - Major

### 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):  
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**  
During the previous inspection the inspectors saw that the two residents admitted for respite care did not have a contract of care, despite being resident for four to six weeks. On this inspection, no residents had been admitted for respite care. The inspectors viewed a sample of the contracts of care for long stay residents which were seen to relate to the care and welfare of the resident in the centre. Contracts included details of services to be provided, the fees to be charged and comprehensive details of any additional services that may incur an additional charge. The contracts identified the room to be occupied by the resident and had been updated to reflect the increase in fee for 2017.

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:
As highlighted in recent inspection reports, inspectors found the registered provider continued to neglect duties set out under Regulation 21 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. Under Schedule 2 and 4, the registered provider is required to maintain a record of all staff currently employed in the centre, and specific documents for the person in charge and for each member of staff. During the current inspection, the provider produced a list of current staff that was not corroborated by staff files, previous lists provided to the Authority, the training matrix and the duty roster. Previous inspections outlined the need to use full names for staff in official documents. However, the provider continued to refer to staff on the roster on a first name basis, failed to accurately update or replace staff who did not show up for rostered duties, and sometimes used two different names or nicknames for staff in different records. The staff training matrix, made available to inspectors on the day of inspection, was not up to date and was missing a number of staff. A thorough audit of records by inspectors identified 31 staff in total as currently employed in the centre.

Inspectors reviewed a sample of staff files for the 31 staff employed. While inspectors recognised that efforts had been made to improve and audit these files, one member of staff in a senior position was without any staff file and this had been flagged as an issue on previous inspections. Other staff files were incomplete and some were missing; references, CVs, Garda vetting, details of correspondence, reports, the dates employment commenced and ceased, the position held and work performed, which is required by legislation.

On inspections in January and July 2017, staff had been recently recruited and did not have Garda vetting in place. 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 that this was a major non-compliance during previous inspections and assured inspectors that she had commenced the process of applying for Garda vetting. Staff without vetting were removed from duties until satisfactory vetting was in place. However, on the 17 October 2017, inspectors found staff had continued to be recruited and employed without satisfactory vetting. During the current inspection, the inspectors identified one staff working at the centre without appropriate vetting and a number of staff without references being attained for them. This included the recently recruited person in charge, where the provider had not secured references from her previous employers. Although staff files were commenced for part time staff these files did not contain all the requirements of schedule 2.

The issue of recruitment had also been raised with the registered provider during a meeting in HIQA headquarters in March 2016. The registered provider had
acknowledged that the person involved in recruitment at the time did not have the appropriate experience or expertise. The provider assured the Deputy Chief Inspector that this responsibility would be delegated to the person in charge. On the day of the inspection the person in charge was working on the staff files.

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

Findings:
There were some systems in place to safeguard resident’s money. 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.

During the last number of inspections, the inspectors identified issues with the management of finances for residents who the provider was acting as a pension agent for. The administrator was a pension agent for a number of residents and a sample of records viewed showed that pensions were collected and then paid directly into the nursing home account. The department of social protection requires that the full amount must be paid to the resident before any deductions can be made. However these residents did not have personal bank accounts and inspectors saw that sums of money were being paid into and held within the nursing home account and not in a separate resident account. The provider deducted the money required for their care and generally returned the money to resident in block payments. This goes against the requirements of the social welfare which requires the balance of payment to be lodged to an interest bearing account for the resident. It also requires that there should be clear separation between the residents account and that of the service. On this inspection the inspectors found that the provider had made progress on the opening of individual accounts and there was documentary evidence of this. All the account details had been forwarded by the provider to the social welfare office for pensions to be paid into. However the accounts were not fully operational by the pension office at the time of the inspection.

Since the previous inspection progress had also been made in the provision of
safeguarding and responsive behaviour training however not all staff had received this training this is discussed further and actioned under Outcome 18 Staffing.

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

**Findings:**
On the previous inspection it was identified that not all staff had received fire training and regular fire drills were not taking place. During this inspection inspectors saw that more frequent fire drills had taken place however a number of staff had either; not received fire training, training was out of date, or they were not recorded or certified on the training matrix. Fire drill records contained evacuation times and dates but did not include any additional comments, learning or a record of staff attendance. Inspectors spoke to one staff that had not received training or attended a fire drill in the centre and therefore the risk to residents by not knowing what to do in the case of fire was higher. The provider said all staff had received induction training on the fire alarms, fire zones and fire panel however this was not reflected on the training matrix. Regular servicing records of fire equipment and emergency lighting were viewed by inspectors and in-house fire safety checks were being recorded.

The inspectors arrived to the centre at 11.00hrs to find that the centre did not have any electricity. The power had been cut the previous day around 13.00hrs due to extreme weather conditions. The provider had been in constant contact with the power network trying to establish when power would be restored however this information was not available at that time but did become available at 14.00hrs when the provider was informed it would not be back until the next day. The provider did not have a generator to maintain essential services in the centre and at the commencement of the inspection had not tried to source a generator. The inspectors insisted that a generator was required to maintain essential services in the centre and at the commencement of the inspection the power went out to ensure the safety and comfort of the residents. Following the opening meeting the provider went to source a generator, this was eventually sourced and was about to be installed when the power was returned at 19.45hrs.

There was a risk to residents due to the lack of having essential equipment such as a generator. During the power outage there was no heating in the centre, there was no lights with the exception of tea lights and torches. Residents had to use the bathroom and get dressed for bed with only the use of a torch. A risk register was maintained in the centre and an incident and accident log recorded recent falls. A key strategy to
mitigate the risk of falls was the need for adequate lighting. Call bells were not working and residents had to call out if they required attention from staff. The emergency lighting only remained in place for five hours after a power cut so that was not available. The inspectors saw numerous fire doors wedged open with wedges, blankets and other items as the hold back mechanisms were not working.

Resident’s essential equipment such as pressure relieving mattresses and nebulisers were not working. However arrangements were in place to reposition residents more frequently in response to the non availability of the specialist mattress. Magnetic doors were not locked and exits were not alarmed. This increased the risk of absconision by residents and also meant that residents could potentially access the laundry, as the electronic keypad access system was disabled. Inspectors found keys in open cupboards where harmful cleaning chemicals were stored.

Infection control was also of concern for inspectors. Maintaining good hygiene standards in bathrooms with poor lighting would be difficult. Inspectors also noted a torn mattress exposed in one room, this was replaced during the inspection. Torn upholstery was also seen in chairs in the day rooms and temporary bed curtains in use which had not been replaced since 2014. Urinals were inappropriately stored in resident's bedrooms and communal bathrooms. A recent reduction in staff numbers also meant that some care staff also performed kitchen duties when required throughout the day. This presents an increased infection control risk.

Gas cylinders were stored behind a wire cage in the enclosed patio area behind the nursing home. However, there was no cautionary signage in place.

**Judgment:**
Non Compliant - Major

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

**Findings:**
Inspectors followed up on action taken by the registered provider following recent inspections, with regard to the complaints process. Since July 2017, inspectors could see that complaints were being recorded both in the complaints log and residents' notes. A new template for recording complaints had been developed. This included; details of the complaint, action taken and resulting learning and improvements made on foot of the complaint. Each complaint was signed off and dated by the person in charge.
Complaints made also formed part of weekly key performance indicator (KPI) data. However, the new template form still did not contain a specific section to record whether the complainant was satisfied with the outcome of the complaints process.

**Judgment:**
Substantially Compliant

### Outcome 18: Suitable Staffing

**Theme:** Workforce

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

**Findings:** Since the previous inspections, there had been an emphasis on staff training and the majority of the 31 staff had received mandatory training. A staff training matrix had been developed and updated to reflect staff working in the centre. However, the matrix given to inspectors on the day of inspection was incomplete. Some staff listed had since left the centre and some staff currently employed were not included on the matrix list. The matrix indicated where training certifications were in the process of being acquired from other centres, but training had not been confirmed. Some staff had also received no training in fire, safeguarding or responsive behaviour.

As previously identified a number of part-time staff had not received fire training or participated in a fire drill, putting the safety of residents at risk, particularly if they were one of two staff scheduled for night duty. The matrix continued to identify gaps in the provision of safeguarding training for the administrator dealing with residents’ finances, maintenance, and other staff. A number of staff were missing responsive behaviour training. The schedule for mandatory training in the centre’s staff training policy conflicted with the frequency of retraining specified in forms in staff files. This policy required updating to accurately reflect the centre-specific approach to training, induction and appraisal.

No record of induction training was found in the sample of staff files reviewed and an induction training checklist was not produced following a request by inspectors. There continued to be no system for staff appraisals in place, however, inspectors were assured by the provider that the new Person in Charge would reinitiate this process. While management meetings had recommenced, there was no record of other staff...
meetings being held.

Inspectors highlighted in a July 2017 inspection report that staffing levels required review to ensure that the number and skill mix of staff was appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre. Resident occupancy had also fallen from 22 to 18 since July 2017 when the provider had ceased to admit new residents to comply with non-standard conditions attached to the centre’s registration which the provider was now compliant with. However, inspectors noted that under current conditions staff found it difficult to perform all assigned tasks, particularly around lunch time and in the evenings when residents required assistance to go to bed. There were two care staff and one nurse and the person in charge on duty during the day from Monday to Thursday. One care staff assisted with mealtimes in the kitchen, the nurse was required to assist a maximum dependency resident with meals and the other carer assisted the remainder of residents. It was difficult for staff to also run activities for residents and take their own breaks during the day. One carer finished at 17.00hrs, which meant that just one nurse and carer were available to residents from then until 8.00hrs the next morning. Concern was also raised by inspectors over the number of staff working in the centre on a part-time basis with full-time jobs elsewhere. Inspectors were concerned regarding the sustainability of such working arrangements.

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:

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

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</tr>
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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:
There was not a person allocated to take charge of the centre in the absence of the person in charge as was identified on the governance plan supplied to HIQA.

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

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
There has been a change of management staff with the appointment of a new PIC on the 25th of September and a new governance manager on the 16th of August. Both of these staff requires time to bed into the organisation before their performance can be measured and outcomes achieved. Going forward the PIC will recruit staff & ensure compliance with all aspects of the legislation. This will be monitored by both the provider and the governance manager at the regular management meetings that are now occurring weekly.

Proposed Timescale: Ongoing

Proposed Timescale:
Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Overall the inspectors were not satisfied that the current governance arrangements were sufficiently robust this was evidenced by poor recruitment practices, lack of emergency planning, lack of progress on the governance and management plan submitted to HIQA and continued levels of non-compliance in the centre.

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:
In the absence of the PIC (outside her normal contracted hours) the nursing home is supported by the governance manager, the registered provider and the staff nurses on duty. Recruitment of a deputy PIC has been delayed due to circumstances outside of our control. A suitable candidate has been sourced and is awaiting a start date. This appointment will be reviewed in due course if the delay is for an extended period.

Proposed Timescale: Ongoing

Proposed Timescale:

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:
During the current inspection, the provider produced a list of current staff that was not corroborated by staff files, previous lists provided to the Authority, the training matrix and the duty roster. Previous inspections highlighted the need to use full names for
staff in official documents. However, the provider continued to refer to staff on the roster on a first name basis, failed to accurately update or replace staff who did not show up for rostered duties, and sometimes used two different names or nicknames for staff in different records. The staff training matrix, made available to inspectors on the day of inspection, was not up to date and was missing a number of staff.

One member of staff in a senior position was without any staff file and this had been flagged as an issue on previous inspections. Other staff files were incomplete and missing; references, CVs, Garda vetting, details of correspondence, reports, disciplinary action, the dates employment commenced and ceased, the position held and work performed, which is required by legislation.

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:
All staff files have been audited and stored appropriately in nurses station in a locked cabinet. We are currently awaiting the remaining outstanding references & training certs. Staff rota updated to show full names.

Proposed Timescale: Ongoing

Proposed Timescale:

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
On this inspection the inspectors found that the provider had made progress on the opening of individual accounts for residents who the provider was acting as pension agent for. All the account details had been forwarded by the provider to the social welfare office for pensions to be paid into. However the accounts were not fully operational at the time of the inspection.

4. 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:
Individual bank accounts opened for residents which are fully operational and ready for payments. All documentation with pension office in order to pay into the individual accounts.

Proposed Timescale: 15/12/2017
### 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 inspectors found that there was a lack of emergency planning in the centre. The provider did not have a generator to maintain essential services in the centre and at the commencement of the inspection had not tried to source a generator.

5. **Action Required:**
Under Regulation 26(2) you are required to: Ensure that there is a plan in place for responding to major incidents likely to cause death or injury, serious disruption to essential services or damage to property.

Please state the actions you have taken or are planning to take:
In the event of an emergency eg lack of power a generator is now available. Emergency plan and policy updated to reflect this. Copy of plan sent.

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<th>Proposed Timescale: 29/11/2017</th>
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<td><strong>Theme:</strong> Safe care and support</td>
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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Infection control was of concern for inspectors. Issues included;
- maintaining hygiene standards in bathrooms with poor lighting
- torn upholstery in chairs in day rooms
- temporary bed curtains in use which had not been replaced since 2014
- urinals were inappropriately stored in resident’s bedrooms and communal bathrooms

6. **Action Required:**
Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

Please state the actions you have taken or are planning to take:
Hourly checks in the resident’s bathroom were completed as part of the bedroom chart as documented. Torn upholstery refers to Cushions belonging to residents which they don't want to change.
In relation to care staff performing kitchen duties this is during Mealtimes where they are required to wash-up only – the staff are not engaged in the preparation of food. In these circumstances care staff wash their hands and change into a whitecoat and a t-shirt in advance of entering the kitchen.

The PIC will reinforce infection control standards with all staff at the next team meeting.
Proposed Timescale: 29/11/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Gas cylinders were stored behind a wire cage in the enclosed patio area behind the nursing home. However, there was no cautionary signage in place.

7. Action Required:
Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

Please state the actions you have taken or are planning to take:
Signage now displayed by gas cylinders and daily check done by maintenance.

Proposed Timescale: 29/11/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A number of staff had either; not received fire training, training was out of date, or they were not recorded or certified on the training matrix.

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 ongoing. Fire training is done on induction and nurses are signing checklist daily.
Training matrix has now been updated to reflect current staff employed and the full dates of training completed. All staff have now received relevant fire training.

Proposed Timescale: Ongoing

Proposed Timescale:
Theme:
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Fire drill records contained evacuation times and dates but did not include any additional comments, learning or a record of staff attendance. Inspectors spoke to one staff who had not received training or attended a fire drill in the centre and therefore the risk to residents by not knowing what to do in the case of fire was higher.

**9. Action Required:**
Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
Fire drill takes place 4 times per year. Fire panel and exits checked daily. Fire alarm sounded every Wednesday. New induction template implemented which supplements our existing documentation.

Proposed Timescale: 30/11/2017

**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 new template complaints recording form did not contain a specific section to record whether the complainant was satisfied with the outcome of the complaints process.

**10. Action Required:**
Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

Please state the actions you have taken or are planning to take:
New complaints recording form reviewed and updated to now include section of “whether the complainant was satisfied with the outcome of the complaints process”

Proposed Timescale: 29/11/2017

**Outcome 18: Suitable Staffing**

**Theme:**
Workforce

**The Registered Provider is failing to comply with a regulatory requirement in**
Inspectors highlighted in a July 2017 inspection report that staffing levels required review. Inspectors noted that under current conditions staff found it difficult to perform all assigned tasks, particularly around lunch time and in the evenings when residents required assistance to go to bed. Concern was also raised by inspectors over the number of staff working in the centre on a part-time basis with full-time jobs elsewhere. Inspectors questioned the sustainability of such working arrangements.

11. **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:**
There has been a change of management staff with the appointment of a new PIC on the 25th of September and a new governance manager on the 16th of August. These staff are an addition to the current skill mix present in the centre.
PIC will commit to reviewing the staffing levels required in relation to the assessed needs of the current residents.

**Proposed Timescale:** 08/12/2017

**Theme:** Workforce

12. **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:**
The training matrix has been updated to reflect the current staff employed and this will be reviewed on a monthly basis at the management meetings to ensure training is complete and up-to-date.

**Proposed Timescale:** Ongoing

**Proposed Timescale:**

**Theme:**
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
No record of induction training was found in the sample of staff files reviewed and an induction training checklist was not produced following a request by inspectors. There continued to be no system for staff appraisals in place. There was also no record of staff meetings being held.

13. **Action Required:**
Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

**Please state the actions you have taken or are planning to take:**
Staff appraisals to be completed by 15/12/17 Induction training checklist now in place.

**Proposed Timescale:** 15/12/2017