

**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: 05 July 2017 09:10 To: 05 July 2017 19:15

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 03: Information for residents	Non Compliant - Moderate
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	Compliant
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Compliant
Outcome 13: Complaints procedures	Non Compliant - Major
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 sixteenth 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, an inspection in January 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 this inspection, the inspectors saw that the condition which directed the registered provider not to accept any further admissions to the designated centre had been breached. The engagement by the provider with

HIQA in recent months has been unsatisfactory.

During this inspection, the inspectors met with residents, staff members, the administrator, the person in charge and a pharmacist. 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. 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.

A busy activities schedule was planned for residents. On the morning of the inspection, inspectors saw residents enjoying mass in the day room, accompanied by a talented voluntary musician. Basketball was scheduled for that evening but care assistants had decided to take advantage of the fine weather and take some residents outdoors. Sonas and other group activities were organised throughout the week. Residents were kept informed of local and national events through the availability of newspapers, radio and television. Residents with whom inspectors spoke were very happy with the level of activities and said there was always plenty of entertainment. 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. Residents 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.

On the previous inspection, the provider was in the centre on a regular basis, however staff say the provider is now only in the centre infrequently and that there are no suitable arrangements in place to address the long term absence. There have been a number of issues with poor recruitment practices and maintenance of staff files identified as non-compliances in previous inspections and HIQA had issued a notice of proposal to refuse the application for registration renewal in 2016. The provider attended a meeting, at that time in HIQA head office and submitted representation to HIQA which outlined plans to address 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 assurances 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 continued to be counted as the nurse on duty during the day to care for the 22 residents present at the time of inspection, and only had six hours supernumerary time to undertake her managerial and regulatory duties. Six hours supernumerary time proved to be insufficient to undertake her governance and management role. She was also the trainer for safeguarding and responsive behaviours and did not have

time to provide this mandatory training to staff. Since the previous inspection a senior nurse/deputy person in charge had been recruited, unfortunately this nurse is currently out on leave so the person in charge continues to have only part time nurses to assist her in her role and there was very limited administrative support available. As the provider had not been in the centre on a regular basis there have been no management meetings held, no staff meetings held, and there is very limited time for any quality assurance.

A number of significant issues were identified by inspectors during previous inspections regarding unsatisfactory practices in the recruitment of staff, lack of provision of fire training and other mandatory training for staff, poor governance and a lack of senior staff. On this inspection, there had been little improvements seen. Fire training had been provided to staff but not all staff had received it. Other mandatory training had not been provided. Recruitment practices continued to be unsafe, with inspectors identifying gaps in vetting procedures, and staff commencing employment without appropriate vetting and references being attained for them. 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 Garda vetting. The person in charge was made aware this was a major non-compliance and informed the inspectors that 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 inspectors identified as they did on the previous inspection, that there were staff working in the centre without any staff files. Following the previous inspection, the inspectors were given assurances that issues with recruitment would all be prioritised and rectified. However inspectors found this had not happened. The inspectors also found that there was not a robust system in place for the management of complaints by residents. Overall inspectors concluded that the current governance and management arrangements of the centre was not effective.

On this inspection, the centre was found to be non-compliant in eight of the eleven outcomes inspected against, three of these outcomes at major non-compliance, five at moderate non-compliance and compliance in the other three outcomes. 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 but particularly in the breach of a condition of registration as discussed above. 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 by the person in charge and staff. 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 changes to the menu and activity schedule, and residents spoken with confirmed that these were facilitated.

Overall inspectors found the current governance and management of the centre was ineffective. On the previous inspection, the provider was noted to be in the centre on a regular basis, however staff say the provider is now only in the centre on an infrequent basis. No contingency plans had been put in place to address this absence. 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. Due to the high levels of non-compliance and ineffective governance arrangements at the previous inspection HIQA had attempted to positively engage with the provider regarding these non-compliances but engagement by the provider was limited. Following that 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 this inspection, the inspectors saw that the condition which directed the registered provider to not accept any further admissions to the designated centre had been breached.

Major non-compliances in the safe and robust recruitment of staff and moderate non-compliance in the provision of up-to-date mandatory training for staff identified on the previous inspection remained ongoing on this inspection despite assurances from the provider verbally and via the action plan response to the inspection report that this

would be prioritised and completed. The person in charge continued to be counted as the nurse on duty during the day to care for the 22 residents present at the time of inspection, and only had six hours supernumerary time to undertake her managerial and regulatory duties. Six hours supernumerary time proved to be insufficient to undertake her governance and management role. Particularly in light of a lack of support from a management team and administration support. She was also the trainer for safeguarding and responsive behaviours and did not have time to provide this mandatory training to staff.

During the previous inspection, the inspectors identified that there was a lack of cover of regular full time nurses or a person participating in management to act up in the absence of the person in charge. Since the previous inspection, a senior nurse/deputy person in charge had been recruited, unfortunately this nurse is currently out on long term leave so the person in charge continues to have only part time nurses to assist her in her role and there was very limited administrative support available. Since the previous inspection, the person in charge took over three weeks leave and nobody was allocated to act as person in charge in her absence. Her shifts were covered by competent part time nurses but there was nobody allocated to cover for her managerial responsibilities. As the provider had not been in the centre on a regular basis there have been no management meetings and no staff meetings held. There is very limited time for any quality assurance. On the previous inspections, 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. This was based on national standards and quality data and 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).The person in charge tallied the number of falls on a weekly basis but was not allocated enough time to conduct more in-depth auditing. Also, as previously outlined due to limited managerial time some of the quality management systems had not continued and the quality improvement meetings had not taken place. On the previous inspection, the provider assured the inspectors the governance meetings would recommence. However, on this inspection the inspectors saw they had not.

There have been issues with poor recruitment practices and maintenance of staff files identified as non-compliance in a number of previous inspections, and HIQA had issued a notice of proposal to refuse the application for registration renewal in 2016. The provider attended a meeting at HIQA head office at that time 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. There was evidence of poor compliance with regulatory requirements in that from the actions required from the previous inspection only the actions in relation to medication management and premises issues had been fully completed. Some actions were partially completed in relation to the provision of fire training to staff and care

plans were put in place for responsive behaviours. The other actions remained non-compliant and the inspectors identified three major non-compliances and five moderate non-compliances on this inspection therefore the centre was found to be non-compliant in eight of the eleven outcomes inspected against, and compliant in the other three outcomes. Overall the governance of the centre required immediate review and action. There was not a clearly defined management system in place and inspectors found the current governance and management of the centre was ineffective. The person in charge was not supported in her role nor did she have adequate management time to undertake her managerial and regulatory responsibilities. Managerial roles were not clearly outlined and the structure did not specify roles, and detail responsibilities for all areas of service provision.

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):

No actions were required from the previous inspection.

Findings:

There was a residents' guide available in the centre. This guide was compliant with regulations as it contained a summary of services and facilities in the centre, the terms and conditions related to residence, a summary of the complaints process and the arrangements for visits.

The inspector viewed the contracts of care for residents which were seen to relate to the care and welfare of the resident in the centre and 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. However two new residents who were in for respite care did not have a contact of care despite them being in for four to six weeks.

Judgment:

Non Compliant - Moderate

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:

On the previous inspections, inspectors found that a sample of staff files did not contain all of the information required under Schedule 2 of the Regulations. Staff that had been recently recruited and maintenance personnel 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 this was a major non-compliance 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.

During the course of a number of previous inspections, there has been on-going non compliance with regard to recruitment and the maintenance of staff files in this centre. For this reason, inspectors planned to more comprehensively review staff files on this follow-up inspection. A full list of staff employed in the centre was not available to inspectors but thirty-one staff were counted by looking at staff files, the roster and a signature sheet. In summary, nineteen staff had staff files, three had some documentation with regard to recruitment and seven had no Garda vetting. Staff without staff files and Garda vetting had been identified on the previous inspection. The provider had taken some steps to attain vetting for some of the staff identified on that inspection as outlined in the action plan. However, this was not available for all staff and further staff were recruited and vetting records were not available to remedy the situation. One newer member of staff commenced employment in May 2017, but management had not received Garda vetting clearance until a month later. This same staff member did not have any references on file. Inspectors also saw that while a number of staff files were marked as audited, gaps remained in CVs with regard to work experience. Staff files were not maintained in line with best practice in record keeping and as previously identified there were no staff files available for a number of staff. Inspectors found it difficult to access some records which were not available at the time of the inspection.

Due to issues of noncompliance on the previous inspection, the Chief Inspector decided

to attach two additional conditions to the registration of this centre. These conditions restricted all admissions until regulatory non-compliances were addressed. A new certificate of registration was issued to the provider on the 15 June 2017. However, the person in charge was not aware of new additional conditions and had not seen the new certificate. An older version of the certificate was on display at the entrance to the centre and the new certificate was not displayed as is required by the Health Act.

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:

On the previous inspection although measures were in place to protect residents from being harmed or suffering abuse, there were new staff employed that did not have training in safeguarding. Also, on that inspection not all staff had received training in responsive behaviours. The person in charge usually provided this training to staff. However, due to time constraints and no one to act up for the person in charge she has not been able to provide the updated training required and the centre remains non-compliant in this outcome.

Systems were 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 for chiropody and hairdressing however these were not available to the inspectors as the administrator said the provider had them at home, as she was undertaking invoicing at home. The provider was a pension agent for a number of residents and again the inspectors did not have access to this information as the provider was the only one with access to these and she was not available during the inspection. The inspectors were unable to see whether residents had individual accounts or whether sums of money were being held within the nursing home account.

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):

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

Findings:

On the previous inspection, not all staff had up-to-date fire training. While inspectors saw that some staff had received training in fire safety and evacuation drills from an external company since the previous inspection, a number of staff were still overdue annual fire training or had not participated in bi-annual fire drills. In-house drills were not being organised and there were no plans to organise such drills for residents or simulate night-time evacuations. This was highlighted by inspectors as a particular risk, as just one nurse and care assistant are rostered to work nights.

Following the last inspection, the provider had stated that quarterly servicing of emergency lighting was taking place and documentary evidence was available to support this. However, inspectors did see that emergency lighting had been serviced in March 2017.

Inspectors found suitable fire equipment was available throughout the centre. Fire evacuation procedures were prominently displayed. A manual call point was tested on a weekly basis, followed by an inspection of door release mechanisms and the fire panel. While fire exits were seen to be unobstructed this was not included during in-house checks carried out on a daily basis, as recommended in HIQA Fire Precautions in Designated Centres, 2016.

Inspectors saw that a record of all incidents was maintained in the centre. Eight incidents had been recorded since the last inspection. Each incident report described details of; the date, location, witnesses, details of the event, reporting, comments, observations, preventative action, and a staff signature. Most incidents recorded were falls and falls risk assessments were available for residents perceived to be at an increased risk. These included a strategy to manage, reduce and eliminate falls. The person in charge tallied the number of falls on a weekly basis but was not allocated enough time to conduct more in-depth auditing. This is discussed under outcome 2 Governance and management.

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):

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

Findings:

On the previous inspection, inspectors found that 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. On this inspection, inspectors saw that medications that required crushing were all individually prescribed by the GP for the two residents that required this format of medication. A list of medications that can and cannot be crushed had been supplied by the pharmacist and was available for all nursing staff.

The inspector met one of the pharmacists during the inspection who was reviewing all residents medication charts and prescribed medications. The pharmacist confirmed that she attends the centre on a monthly basis to conduct a review of the residents' medications and liaises with the General Practitioner (GP) if any changes are required. She also conducted audits of medication management in the centre and ensured appropriate stocks of medications. She confirmed that her colleague was available and had provided training and updates on medications to nursing staff and residents if required.

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 with best practice guidelines and nurses were checking the quantity of medications at the start of each shift.

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. As required medications stated frequency of dose therefore ensuring there was a maximum dose in 24 hours that could not be exceeded.

Judgment:

Compliant

Outcome 10: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Inspectors saw that a record of all incidents and accidents was maintained in the centre. Most incidents which occurred were falls with minor injuries and did not require reporting to HIQA. The person in charge submitted quarterly reports to the Authority to notify the Chief Inspector of any incident which did not involve personal injury to a resident. However, no such notifiable events had occurred during the first quarter of 2017.

Judgment:

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):

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

Findings:

On the previous inspection the inspectors found 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. On this inspection inspectors saw that responsive behaviour care plans were in place for all residents exhibiting responsive behaviours and there was evidence in the form of a signature sheet that staff had read and understood

the plans. The person in charge and staff said that responsive behaviours have been reduced significantly since the previous inspection.

Inspectors viewed the care plans of a number of residents including two residents that were admitted for respite care. 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. The long stay residents had a care plan developed within 48 hours of their admission based on their assessed needs. The inspectors saw that two residents on respite care had comprehensive assessments undertaken on admission. However, comprehensive care plans were not put in place for these residents. One resident was documented to be non-weight bearing yet there was no mobility plan in place as to how the resident should be transferred or no wound care plan in place for the checking of the resident's surgical wound. Care plans that detailed the interventions necessary by staff to meet residents' assessed healthcare needs are essential to direct care, particularly in light of the number of different part time nurses working in the centre.

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):

The action(s) required from the previous inspection were 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. Since the previous inspection room 10 had been extended to a large very bright room which was now single occupancy. The inspector spoke to the resident in room 10 who was particularly happy with the accommodation and care in the centre.

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. 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. Equipment servicing records were up to date and there was a functioning call-bell system in place. On the previous inspection, 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. On this inspection these had been replaced.

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.

Judgement:

Judgment:

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):

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

Findings:

Following the previous inspection the provider submitted an action plan to the Authority which stated the complaints policy had been updated to instruct staff to record all complaints including verbal complaints, in the complaints register, in addition to the relevant resident's care plan. Inspectors checked the complaints policy and saw that it had not been updated since the last inspection. No new complaints had been recorded in the complaints register since the last inspection but inspectors found, after speaking with a number of residents, that they had made complaints recently to management. One complaint involved a resident whose property had gone missing the previous weekend. This had been recorded in nursing handover notes but not in the resident's care plan or complaints register. Another complaint was ongoing with three weeks regarding a resident's personal finances. While management had taken steps to reassure this resident, the complaint and actions taken had not been properly recorded. The correct procedure was not being followed with respect to the complaints procedure, residents were not aware of the appeals process and had no access to advocacy services.

The complaints template for recording complaints did not contain a specific section to record whether the complainant was satisfied with the outcome of the complaints process. There also appeared to be no monitoring of the complaints process and the

system in place did not present an opportunity for learning and improvement.

Judgment:

Non Compliant - Major

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:

During the previous inspection, inspectors saw that not all staff had received mandatory training in; fire, infection control, moving and handling, safeguarding, and responsive behaviour. It had been difficult for inspectors to accurately assess gaps in training as no training matrix or effective training summary records were available. The action plan following the last inspection stated that a training matrix had been completed and training dates had been scheduled for staff. On this inspection, inspectors saw that a training matrix had been compiled but did not list all staff employed in the centre. Some of the scheduled training had not taken place, as the person in charge who was qualified to deliver some of the training, was not freed from nursing duties. As a result many staff were still either overdue training or had not received training in different relevant areas.

Based on inspection findings, inspectors had concerns the centre was not always sufficiently staffed to meet the assessed needs of residents. Most nurses worked on a part-time basis, many of which were missing staff files and had not participated in mandatory training. The provider was not available to adequately supervise staff, conduct appraisals, approve staff requests or participate in recruitment processes. Just one management meeting had taken place since the last inspection. The person in charge had represented staff concerns to an administrator, but the provider was not present and no actions were seen to arise from this meeting. Evidence was seen meeting minutes, and confirmed during interviews by inspectors with staff, that they felt under pressure to complete duties particularly during mealtimes and at night. While staff were willing to work harder to cover absenteeism, it was not a long term solution.

Inspectors saw strong evidence that staff were not recruited, selected and vetted in

accordance with best recruitment practice and in line with the requirements of Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. This is addressed in more detail under Outcome 2, Governance and Management, and Outcome 5, Documentation to be kept at a designated centre.

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
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Action Plan



Provider's response to inspection report¹

Centre name:	Rochestown Nursing Home
Centre ID:	OSV-0000275
Date of inspection:	05/07/2017
Date of response:	25/07/2017

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:

There was not a clearly defined management system in place inspectors found the current governance and management of the centre was ineffective. The person in charge was not supported in her role nor did she have adequate management time to undertake her managerial and regulatory responsibilities. Managerial roles were not clearly outlined and the structure did not specify roles, and details responsibilities for all areas of service provision.

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

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:

Unplanned and long-term sickness of two management personnel, have impacted on the governance and management arrangements. The provider has committed to submitting a detailed plan to the Authority to address these issues.

Proposed Timescale: Plan to be submitted 27th July 2017

Proposed Timescale:**Theme:**

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

There were not management systems in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored. As the provider had not been in the centre there have been no management meetings held no staff meetings held and there is very limited time for any quality assurance. On the previous inspection the provider assured the inspectors the governance meetings would recommence. However on this inspection the inspectors saw they had not.

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:

Management meetings will recommence immediately with the first meeting taking place on 25/07/2017. Following this the meetings will be scheduled for every week.

The PIC has been instructed to hold staff meetings also every 4 weeks.

Proposed Timescale: Ongoing

Proposed Timescale:**Outcome 03: Information for residents****Theme:**

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The two residents who were in for respite care did not have a contact of care despite them being in for four to six weeks.

3. Action Required:

Under Regulation 24(1) you are required to: Agree in writing with each resident, on the admission of that resident to the designated centre, the terms on which that resident shall reside in the centre.

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

Signed contract of care is in place for all long term residents and any residents who may be admitted in future on respite to have contract of care.

Proposed Timescale: 25/07/2017

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:

Inspectors found it difficult to access some records which were not available at the time of the inspection.

4. Action Required:

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

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

Accounting records were temporarily removed from the nursing home to allow the provider to work from home during sick leave. These records have since been restored.

Proposed Timescale: 25/07/2017

Theme:

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Significant and ongoing issues have been identified by the lack of information contained in staff files over the course of numerous inspections. On this inspection serious gaps

were seen in the documentation maintained for staff. A full list of staff employed in the centre was not available to inspectors but thirty-one staff were counted by looking at staff files, the roster and a signature sheet. In summary, nineteen staff had staff files, three had some documentation with regard to recruitment and seven had no Garda vetting. Staff without staff files and Garda vetting had been identified on the previous inspection but the provider had not taken steps, as outlined in the action plan, to remedy the situation. One newer member of staff commenced employment in May 2017, but management had not received Garda vetting clearance until a month later. This same staff member did not have any references on file. Inspectors also saw that while a number of staff files were marked as audited, gaps remained in CVs with regard to work experience.

5. 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:

A new member of staff is to be recruited in relation to governance and management. This will be outlined in the proposed Governance and Management plan which is to be submitted on the 27/07/17.

Due to a number of emergency unplanned absences of nursing staff there was a reliance and urgent need to provide emergency cover of nursing staff on an ad-hoc basis. This practice has now discontinued and a number of these staff have now been placed on a bank system which will ensure that all of the necessary staff files are in place should emergency cover be required from this staff pool in future.

Proposed Timescale: 30/09/2017

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 responsive behaviour training.

6. 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:

Training in responsive behaviour has been scheduled to take place on 15th August 2017

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:

Not all staff had up-to-date training in the detection and prevention of and responses to abuse.

7. 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:

Staff training in the detection and prevention of and responses to abuse has been scheduled for 8th of August 2017

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:

The provider was a pension agent for a number of residents but the inspectors were unable to establish if residents had individual accounts and if receipts were available as the provider had all the accounts at home on the day of the inspection and therefore were not available for inspection.

8. 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:

It is planned for the nursing home to set up another nursing home company account which would be used only for the purposes of paying residents pensions into.

Proposed Timescale: 30/08/2017

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:

Not all staff had received up to date fire training.

9. 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:

Fire training has been scheduled for 10th of August with Argos Fire & Safety

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:

Regular fire drills were not taking place in the centre.

10. 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 drills will now take place twice yearly as recommended. The first drill has been scheduled to take place on 2nd of August 2017

Proposed Timescale: 02/08/2017

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:

The inspectors saw that two residents on respite care had comprehensive assessments

undertaken on admission. However there was not comprehensive care plans put in place for these residents. One resident was documented to be non-weight bearing yet there was no mobility plan in place as how the resident should be mobilised or no wound care plan in place for the checking of the residents surgical wound. Care plans that detailed the interventions necessary by staff to meet residents' assessed healthcare needs are essential to direct care particularly in light of the number of different part time nurses working in the centre.

11. 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:

Comprehensive care plans are now in place for the two residents who were on respite. An audit of care plans will take place in September 2017 to ensure that progress is maintained in this area.

Proposed Timescale: Respite care plans in place: Completed; Audit: to be complete September 2017

Proposed Timescale: 30/09/2017

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

12. 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:

The policy for complaints and the template have now been amended to ensure there is a specific section to record the complainant's satisfaction with the outcome of the complaint process.

Proposed Timescale: 25/07/2017

Theme:

Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Inspectors found, after speaking with a number of residents, that they had made complaints recently to management. One complaint involved a resident's missing property the previous weekend. This had been recorded in nursing handover notes but not in the resident's care plan or complaints register. Another complaint was ongoing with three weeks regarding a resident's personal finances. While management had taken steps to reassure this resident, the complaint and actions taken had not been properly recorded. The correct procedure was not being followed with respect to the complaints made and residents were not aware of the appeals process and had no access to advocacy services.

13. 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:

The two complaints are now fully recorded in the complaints register and the care plans updated as required to reflect the learning from the complaints.

Proposed Timescale: 25/07/2017

Outcome 18: Suitable Staffing

Theme:

Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Staffing levels required review 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.

14. 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:

A staffing levels review will be undertaken to assess the number and skill mix of staff

based on current resident's dependencies.

Proposed Timescale: Review to be complete 11th August 2017

Proposed Timescale: 11/08/2017

Theme:

Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Inspectors saw that a training matrix had been compiled since the last inspection. However, it did not list all staff employed in the centre. Some of the scheduled training had not taken place, as the person in charge who was qualified to deliver some of the training, was not freed from nursing duties. As a result many staff were still either overdue mandatory training or had not received training in different relevant areas such as moving and handling.

15. 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 staff working at the centre. Mandatory training has been scheduled over a phased basis according to the updated matrix.

Proposed Timescale: Ongoing

Proposed Timescale:

Theme:

Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Staff appraisals had taken place for a long time and a number of staff had never been appraised.

16. 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:

Annual staff appraisals will commence immediately by the PIC and management. Those who have never been appraised will commence first.

Proposed Timescale: Ongoing

Proposed Timescale: