Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Rockshire Care Centre
Centre ID:	OSV-0000688
Centre address:	Rockshire Road, Ferrybank, Waterford.
Telephone number:	051 831108
Email address:	info@rockshirecarecentre.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	RCC Care Limited
Lead inspector:	Vincent Kearns
Support inspector(s):	None
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	37
Number of vacancies on the date of inspection:	1

About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

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 compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
11 April 2018 08:00	11 April 2018 17:30
12 April 2018 07:00	12 April 2018 16:00

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Substantially Compliant	Non Compliant - Moderate
Outcome 02: Safeguarding and Safety	Substantially Compliant	Compliant
Outcome 03: Residents' Rights, Dignity and Consultation	Substantially Compliant	Compliant
Outcome 04: Complaints procedures	Substantially Compliant	Compliant
Outcome 05: Suitable Staffing	Substantially Compliant	Compliant
Outcome 06: Safe and Suitable Premises	Substantially Compliant	Non Compliant - Moderate
Outcome 07: Health and Safety and Risk Management	Substantially Compliant	Non Compliant - Moderate
Outcome 08: Governance and Management	Substantially Compliant	Substantially Compliant

Summary of findings from this inspection

This inspection report sets out the findings of a thematic inspection which focused on specific outcomes relevant to dementia care. As part of the thematic inspection process, providers were invited to attend information seminars given by the Authority. In addition, evidence-based guidance was developed to guide the providers on best practice in dementia care and the inspection process. Prior to this inspection, the person in charge completed the provider self-assessment and compared the service with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and

the National Quality Standards for Residential Care Settings for Older People in Ireland.

The inspector focused on the care of residents with a dementia in the centre. Care practices were observed and interactions between staff and residents who had dementia were rated using a validated observation tool. Documentation such as care plans, medical records and staff training records were examined. The inspector also considered progress on the findings following the previous inspection carried out in May 2017. The inspector noted that a number of the actions from the previous inspection had not been satisfactorily completed.
These actions included providing adequate staff training in dementia care and behaviours that challenge and these actions are restated in the body of this report.

The inspector met with residents, staff members, the clinical nurse manager, the person in charge and provider representative. The inspector tracked the journey of a number of residents with dementia within the service, observed care practices and interactions between staff and residents who had dementia using a validated observation tool. The inspector also reviewed documentation including staff files, relevant policies and the self assessment questionnaire, submitted prior to inspection.

The centre did not have a dementia specific unit and, at the time of inspection there were 21 residents living in the centre with a formal diagnosis of dementia and a further four residents suspected of having dementia. The inspector observed that a small number of residents required a considerable level of assistance and monitoring due to the complexity of their individual needs. Overall, the inspector found the person in charge, the management and staff team were committed to providing a good quality service for residents with dementia. The inspector found that residents appeared to be well cared for and residents gave positive feedback regarding all aspects of life in the centre. The inspector found that residents' overall healthcare needs were met and they had access to appropriate medical and allied healthcare services. There was an activities coordinator however, all staff fulfilled a role in meeting the social needs of residents and staff connected with residents as individuals. The quality of residents' lives was enhanced by the provision of a choice of interesting things for them to do during the day. The inspector noted that there was an ethos of respect and dignity for residents evident. The overall atmosphere in the centre was endeavoring to be homely, comfortable and in keeping with the assessed needs of the residents who lived there. The person in charge had submitted a completed self-assessment tool on dementia care to HIQA with relevant policies and procedures prior to the inspection. The person in charge had assessed the compliance level of the centre through the self assessment tool and the findings and judgements of the inspector generally concurred with the person in charges' judgements.

From the eight outcomes reviewed during this inspection, four outcomes were compliant and one outcome was substantially complaint. However, three outcomes; health and social care needs, health and safety and risk management, and safe and suitable premises were found to be at moderate non-compliance. These non-compliances were discussed throughout the report and the action plan at the end of

the report identified where improvements were needed to meet 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.

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 01: Health and Social Care Needs

Theme:
Safe care and support

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

Findings:
This outcome sets out the inspection findings relating to healthcare, assessments, care planning and medication management. The social care of residents with dementia was discussed in outcome 3.

There were a total of 37 residents in the centre on the days of this inspection, 19 residents had been assessed as having maximum and high dependency needs, 14 residents had medium dependency needs and four residents had low dependency needs. Twenty-one residents had a formal diagnosis of dementia with an additional four residents suspected of having dementia The inspector found that each resident's wellbeing and welfare was maintained by a good standard of nursing care and appropriate medical and allied health care. A selection of residents' files and care plans were reviewed. The inspector focused on the experience of residents with dementia and tracked the journey of four residents with dementia and also reviewed specific aspects of care such as nutrition, wound care and end of life care in relation to other residents. There was evidence of a pre-assessment undertaken prior to admission for residents and a number of residents had been transferred to this centre following admission in an acute hospital services. Each resident had a care plan developed within 48 hours of their admission based on their assessed needs. There was evidence that residents and or their relatives had participated in the development of residents' care plans. Nursing staff outlined to the inspector how they were allocated to provide care and support to individual named residents. This helped ensure consistency of care, for all residents and particularly supported residents with dementia to became familiar with staff providing care. There was a documented comprehensive assessment of the activities of daily living including communication, personal hygiene, continence, eating and drinking, mobility, rest and sleep. There was evidence of a range of assessment tools being used to assess and monitor issues such as falls, pain management, mobilisation and risk of pressure ulcer development. Care plans were also developed to address problems or if a potential

risk was identified. Pressure relieving mattresses were provided and there were a number of residents with wounds and suitable wound care plans were viewed.

There was timely access to dietetic services and specialist advice was incorporated into care plans. Nurses' narrative notes were linked to the care plans. Resident's care plans were kept under formal review on a four monthly basis or as required by the resident's changing needs in consultation with residents or their representatives. Generally residents were satisfied with the service provided. Residents had access to medical services delivered by visiting general practitioners (GPs) and out-of-hours medical cover was provided. Residents had access to psychiatry of later life services and a range of other services was available on referral including speech and language therapy (SALT), chiropody, and optical services. The inspector met the physiotherapist who was based in the centre two-three days a week. Nursing care plans had been updated to reflect the recommendations of various members of the multidisciplinary team. Physiotherapy assessments were included as part of the service and the inspector saw evidence that residents with limited mobility and those at risk of falls had benefitted from physiotherapy input. There were systems in place to ensure residents' nutritional needs were met and there was access to speech and language therapy services and residents received adequate hydration. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked on a monthly basis and more frequently if evidence of unintentional weight loss was observed. Residents were provided with a choice of nutritious meals at mealtimes and all residents spoken to were complimentary about the food provided. However, the inspector noted from a sample of care plans reviewed, that not all residents had oral care plans completed to guide staff in their clinical practice and the review of care provision.

The inspector spoke to the chef and noted that there was an effective system of communication between care and catering staff to support residents with special dietary requirements. Nursing staff told the inspector that if there was a change in a resident's weight, nursing staff would reassess the resident, inform the GP and referrals would be made to the dietician and speech and language therapy services. Files reviewed by the inspector confirmed this to be the case. Nutritional supplements were administered as prescribed. All staff were aware of residents who required specialised diets or modified diets and were knowledgeable regarding the recommendations of the dietician and SALT. Mealtimes in the dining room was observed by the inspector to be a social occasion. Staff sat with residents while providing encouragement or assistance with their meal and whenever possible supported the resident to eat independently. The inspector noted when the main course of the meal was finished staff were observed cleaning off plates into receptors on a trolley in the dinning room. However, the inspector requested the person in charge to review this practice as it appeared to be noisy and unnecessarily distracting for residents with a dementia. There was a room used solely for dinning which helped signal to residents with a dementia that a mealtime was about to take place. This dinning room was located adjacent to the kitchen therefore allowed the smell of food to pass though, encouraging appetite and also reminding residents with dementia that a mealtime was about to take place. There was a good choice provided in relation to menu options and the chef outlined that there was three week rolling menu. The chef spoke to many residents each day and the menu was discussed with each resident by staff. Copies of a printed menu were on display on notice boards and at the entrance to the dinning room. However, the inspector requested that the person in

charge review the format of the menu to ensure that it was dementia friendly.

Residents had access to single rooms for end of life care and families were facilitated to stay overnight, if they wished to do so. Staff were supported by the community palliative care team for symptom relief and to provide end of life care. Staff provided subcutaneous hydration to prevent unnecessary admissions to hospital. The inspector noted that resident's wishes in relation to end of life care was elicited and used to inform a plan of care to meet their holistic needs.

There were centre-specific policies on medication management that were made available to the inspector and had most recently been reviewed in September 2016. The policies included the ordering, receipt, administration, storage and disposal of medicines. The policies were made available to nursing staff who demonstrated adequate knowledge of this document. Medicines were stored in a locked cupboard, medication trolley or within a locked room only accessible by nursing staff. Medicines requiring refrigeration were stored securely and appropriately. The temperature of the medication refrigerator and storage areas was noted to be within an acceptable range; the temperature was monitored and recorded daily. The inspector reviewed a number of medication prescription charts and noted that all included the resident's photo, date of birth, GP and details of any allergy. The person in charge outlined the system of ongoing audit and analysis that was in place for reviewing and monitoring safe medication management practices. Medication errors were recorded and there was evidence that appropriate action was taken as a result of same. Nursing staff undertook regular updates in medication management training as evidenced by training records. Limited self-medication in the centre was facilitated and this practice was supported by a centre specific policy and appropriate assessments. There was adequate and secure storage provided for the residents' medicinal products and access was limited to each individual resident. Nursing staff spoken to outlined adequate evaluation (including on-going evaluation) of the residents' ability to self-administer as appropriate. There was also adequate recording and monitoring practices to facilitate the resident with self-administration. Generally there were adequate systems in place for the handling and storage of controlled drugs in accordance with current guidelines and legislation including the Misuse of Drugs Regulations. One of the requirements for controlled medications was for the stock balance to be checked and signed for by two nurses at the end of each shift. Each balance check was recorded in a controlled drugs stock balance record. However, from a review of this record the inspector noted a number occasions since November 2017 when one of the nurses signature was not recorded.

Judgment:
Non Compliant - Moderate

Outcome 02: Safeguarding and Safety

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 measures in place to protect residents from being harmed or abused. All staff had received training on identifying and responding to elder abuse. There were centre specific policies in relation to protecting residents from abuse, on the management of behaviours that challenge and on the use of restraint. Each was signed and dated by the person in charge. There were also copies of the national Health Service Executive (HSE) policy on safeguarding vulnerable persons at risk of abuse made available to staff. The person in charge, and both day and night duty staff who spoke with the inspector displayed sufficient knowledge of the different forms of elder abuse and all were clear on reporting procedures. Staff spoken to were familiar with these aforementioned policies and knew what to do in the event of an allegation, suspicion or disclosure of abuse. The person in charge confirmed that all staff had Garda clearance and this was found to be the case when a sample of staff files was examined. Residents spoken to also confirmed with the inspector that they felt safe. On the previous inspection it was found that not all staff had all staff had received training in dementia care. However, this action remained open as the inspector noted from the training matrix that not all staff had received training in dementia care. This issue was actioned under outcome 5 of this report.

The inspector reviewed the systems in place to safeguard resident's finances which included a review of a sample of records of monies handed in for safekeeping. The centre maintained day to day expenses for a small number of residents and the inspector saw evidence that complete financial records were maintained. There were transparent arrangements in place to safeguard residents' finances and financial transactions. Money was kept in a locked safe in an office and all withdrawals and lodgements were double signed confirming monies lodged or withdrawn. The provider representative was a pension agent for a small number of residents. In relation to these pension accounts the provider representative informed the inspector that they were compliant with the requirements of the department of social protection.

Overall, the inspector found that staff had the necessary skills and knowledge to work with residents who had behavioural issues. There were 24 residents with dementia in the centre and some of these residents had responsive behaviours. Behaviours described as problematic by staff included verbal and occasional physical aggression and the inspector observed a number of such incidents during this inspection. On the previous inspection, it was found that not all staff had received training in the management of responsive behaviours. However, this action remained open as the inspector noted that most, but not all staff had received training in the management of responsive behaviours. This issue was actioned under outcome 5 of this report. Staff spoken to by inspectors outlined person centred interventions including utilising distractions and de-escalating for example, the use of music, walks in the garden and suitable one to one activities. Files examined showed that assessments and care plans for these residents were person centred. Staff interacted socially with residents and implemented suitable interventions. Choices in relation to activities were offered where possible and residents' individual preferences were respected. Environmental triggers

such as noise levels were generally controlled. However, the design and layout of the large sitting room required review due to it's size, design and layout and this issue is actioned under outcome 6 of this report.

Staff were vigilant to monitor for delirium or underlying infections if there was any change in a resident's mood or behaviour. There was evidence that appropriate referrals had been made to mental health services. Recommendations from the community psychiatric services had been implemented along with person centred interventions with positive outcomes for residents including a reduction in the incidence of responsive behaviours. The inspector concluded that the person in charge and staff worked to create an environment for residents with dementia to minimise the risk of responsive behaviours. Staff displayed competence to assess and plan care in order to provide a consistent therapeutic care for residents with responsive behaviours. The person in charge outlined how the centre was working towards promoting a restraint free environment. For example, by using equipment such as low beds. The inspector noted that there were environmental restraints with all exit doors secured. There were bed rails in place and a number of residents had lap belts and safety alarms fitted. Staff confirmed that bed rails were often used at the request of residents and residents who spoke with inspectors confirmed this. Safety checks were completed and there was documented evidence that these were undertaken. All forms of restraint were recorded in the restraint register and appropriately notified to HIQA. Risk assessments had been undertaken and care plans were put in place for residents who used bedrails. On the previous inspection it was found that not all staff had all staff had received training in the application and use of restraint. However, this action remained open as the inspector noted that most but not all staff had received training in application and use of restraint. This issue was actioned under outcome 5 of this report.

Judgment:
Compliant

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

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

Findings:
As part of the inspection, the inspector spent periods of time observing staff interactions with residents. The inspector used a validated observational tool (the quality of interactions schedule, or QUIS) to rate and record at five minute intervals. The inspector spent time observing interactions during lunch and in the afternoon. These observations took place in the dinning room, the large sitting rooms and "the Parlor room". Overall, observations of the quality of interactions between residents and staff in the communal areas for a selected period of time indicated that the majority of interactions were of a

positive nature with positive connective interactions seen between staff and residents. An activity group was ongoing during one of the observation periods and the activity staff involved every resident in the activity including the residents with advanced dementia.

There was evidence that residents' with dementia received care in a dignified manner that respected his or her privacy. Staff were observed knocking on residents' bedroom doors and seeking the residents' permission before engaging in any care activity. There were no restrictions on visiting times; there were facilities to allow residents to receive visitors in private with rooms separate to residents' bedrooms were visitors and residents could meet. Numerous visitors were observed throughout both days of inspection where staff members knew the names of visitors and vice versa. Staff took time to talk with family members both when they visited and when they rang to enquire about their relative. Residents with dementia and/or their representatives as appropriate, were consulted about how the centre was run and the services that were provided. For example, the person in charge regularly spoke to all residents, a satisfaction survey had commenced in April 2018 and there were regular residents' meetings. The most recent held in November 2018. The inspector noted that any issues raised by residents were acted upon by management. Representatives were welcome to represent residents who were unable to verbally communicate or could not attend the meetings.

Closed circuit television (CCTV) was positioned at the entrance to the building, in corridors, and outside in the grounds. An action from the previous inspection in relation to the use of CCTV and privacy of residents had been completed. Residents' rights, privacy and dignity were respected, during personal care, when delivered in their own bedroom or in bathrooms. Residents spoken with confirmed that they were afforded choice in relation their daily lives and for example, when they got up, what activities they participated in or receive visitors in private. The nursing assessment included an evaluation of the resident's social and emotional wellbeing. Residents had access to radio, television, and information on local events. The inspector observed that some residents were spending time in their own rooms, watching television, or taking a nap. There was a choice of communal areas for activities including a small room off the main large sitting room and upstairs there was another communal sitting room called the "the parlor". The inspector spoke to the activities coordinator who outlined a varied programme of activities that were available to residents whom had a dementia. These activities included sonas, imagination gym, live music, sing-songs, chair based exercise, religious activities, gardening and other more individualised one to one activities. Some residents and/or residents representatives had completed 'Getting to Know Me' records as part of their reminiscence therapy. In addition, the inspector noted that there were "Pool Activity Level" (PAL) assessments which identified cognitive ability, physical and social well being giving insights into residents sense of humor, anger levels, enjoyment, anxiety's or if they had episodes of restlessness. Residents' individual preferences were respected in relation to activities. The inspector observed that residents were free to join in an activity or to spend quiet time in their room. Each resident's preferences were assessed and this information was used to plan the activity programme. The inspector saw a number of group and individual activities being undertaken during the two days of inspection. These included sing-songs, newspaper reading, quiz, live music session and one to one individual sessions. Residents and relatives spoken with gave positive

feedback on the activities and some joined in with the groups. The person in charge confirmed that although they had a number of external people providing activities, and an activities coordinator was available five days a week, it was the role of all staff to provide social stimulation for residents. The inspector observed that staff did spend time sitting and chatting with residents at various times throughout the day. The inspector observed that there were specific activity sessions for residents with dementia both in group and one to one sessions. Some residents said they preferred not to take part in the group activities and the inspector saw that their wishes were respected and individual one to one time was scheduled for these residents, if appropriate. Staff were observed creating opportunities for one-to-one engagement, particularly for residents who had a dementia or who were unable or unwilling to participate in groups. The inspector concluded that the person in charge and staff worked to create an environment for residents with dementia that minimised the risk of responsive behaviours.

Judgment:
Compliant

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

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

Findings:
The actions from the previous inspection had been completed.

There was a policy and procedure for making, investigating and handling complaints dated as reviewed by the person in charge in April 2017. The complaints process was displayed in the main reception area and was also outlined in the statement of purpose and function and in the residents' guide. There was evidence that complaints were discussed at management and staff meetings and informed changes to practice. Staff interviewed conveyed an understanding of the process involved in receiving and handling a complaint. Residents to whom the inspector spoke said that they had easy access to any staff in order to make a complaint. The person in charge was identified as the named complaints officer and residents stated that they felt they could openly report any concerns to any staff and were assured issues would be dealt with. Records showed that complaints made to date were dealt with promptly and the outcome and satisfaction of the complainant was recorded. There was a second nominated a person, other than the person in charge, available in the centre to ensure that all complaints are appropriately responded to and that the person in charge maintained the records specified under in Regulation 34 (1)(f). The complaint process included a local appeals procedure and there was also an independent appeals process.

The inspector viewed a complaints log and saw that complaints, actions taken and outcomes were documented and that feedback was given to the complainant. All complaints were reviewed regularly by the person in charge to identify any learning or changes that were required.

Judgment:
Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

Findings:
Residents and relatives spoke positively of staff and indicated that staff were caring, responsive to their needs and treated them with respect and dignity. This was seen by the inspector throughout the inspection in the dignified and caring manner in which staff interacted and responded to the residents.

Systems of communication were in place to support staff with providing safe and appropriate care. There were handover meetings each day to ensure good communication and continuity of care from one shift to the next. The inspector saw records of staff meetings at which operational and staffing issues were discussed. The inspector saw that staff had available to them copies of the Regulations and standards. In discussions with staff, they confirmed that they were supported to carry out their work by the person in charge. The inspector found staff to be well informed and knowledgeable regarding their roles, responsibilities and the residents' needs and life histories. There was evidence that residents knew staff well and the inspector observed that residents engaged easily with staff in personal conversations.

Staff had received up to date training in safe moving and handling and, safeguarding vulnerable persons. Other training provided included infection control, health and safety and food and nutrition. Nursing staff confirmed they had also attended clinical training including medication management and cardio pulmonary resuscitation (CPR) training. On the previous inspection there was an action in relation to inadequate training of some staff as required by regulation. However, this action remained open as there continued to be inadequate staff training provided in relation to management of responsive behaviours, dementia care and the use of resstraint which was actioned under outcome 2 of this report. In addition, not all staff had received training in fire safety training which was actioned under outcome 7 of this report.

The inspector reviewed a sample of staff files which included the information required

under Schedule 2 of the regulations. Up to date registration for 2018 was seen for nursing staff as required by an Bord Altranais agus Cnáimhseachais na hÉireann, or Nursing and Midwifery Board of Ireland.

From a review of staff files and from speaking to staff the inspector noted all staff were suitably recruited, inducted and supervised appropriate to their role and responsibilities. There was evidence of good recruitment practices including the verification of written references and the on-going appraisal and supervision to ensure good quality care provision and improve practice and accountability.

The staffing rota confirmed that there was a nurse on duty at all times. An improvement in staffing had been an action from the previous inspection and on the days of inspection, there was a full complement of staff according to the staff duty roster. The person in charge confirmed that there were sufficient staff with the right skills, qualifications and experience to meet the assessed needs of the residents. The person in charge outlined recent improvements in staffing which included an increase in the number of staff available to work in the centre to provide additional cover for when unexpected staff vacancies occurred.

Judgment:
Compliant

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

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

Findings:
The centre was a purpose built nursing home that was constructed in 2007 and the overall design and layout of the premises was largely reflective of the period in which it was built. Residents' accommodation was laid out over two floors and residents with dementia were integrated with the other residents in the centre. There were 32 single en suite bedrooms and three twin en suite bedrooms. There were an adequate number of bathrooms and toilets suitably located and accessible. There was a separate hairdressing room, activities room and physiotherapy treatment room. There were a number of lounge areas on both floors which were well furnished and comfortable. The sitting room on the first floor that was called the Parlor and was available for family events birthday celebrations or private meetings and was particularly suitable for residents with dementia. For example, it had been designed with a retro style fireplace, and was overall bright cheerful colour scheme with one wall contained wall paper. There was a homely feel in this room with comfortable high backed arm chairs in a range of different heights and depths which catered for people's personal preferences. The

inspector noted that other furniture included an old dresser table, a old style wall clock, sewing table and the old mahogany round table in the centre of the room that contained a hand crochet linen cloth. The overall effect of this furniture and layout gave a familiar and cosy feel to this room and residents with dementia were observed using this room a number of times with the activities coordinator. There was a large sitting room on the ground floor which included a small library area and led to a well maintained, secure and sheltered garden. This room was bright with natural light from large windows in two walls. There was a large screen television in one corner that was available to support ease of viewing for residents including residents with visual problems. The inspector noted that there had been subdividing of this the extensive floor space to create small cosy areas within popular this room for residents' comfort and enjoyment. However, the inspector observed that this large sitting room area became very was noisy at times potentially increasing tensions and confusion particularly among residents with dementia. In the context the dependency profile of residents with 25 of the 37 residents identified as having dementia, the inspector requested that the provider representative to review the design and layout of this very large room to ensure that it met the needs of residents with dementia.

The first floor was accessible by a lift fitted with a handrail fitted to support residents mobility needs while the lift was moving. The centre was observed to be bright, spacious and well decorated with pictures and photographs that supported the comfort of residents with dementia. There was a separate hairdressing room. A small room adjacent to the large sitting room; that was used as a quiet area for residents to relax in or for facilitating activities with a small group of residents. The inspector saw that some residents personalised their bedrooms with photographs and personal items. The layout and dimensions of the bedrooms met the needs of residents in terms of adequate personal storage space, access for assistive equipment such as hoists and wheelchairs, privacy and dignity. Shared bedrooms had appropriate screening for residents' privacy. The inspector spoke with residents that lived in shared bedrooms who said that they were happy living in their bedrooms. The inspector noted that there had been some decorative improvements completed in some areas for example in the Parlor sitting room room and some parts of bedroom corridors. These areas positively impacted on the quality of life for residents with dementia in the centre. However, there were a number of premises issues including the following:
● the overhead door closer on the staff room door required review as it made a loud noise each time it closed
● there were a number of chairs including some assisted chairs, requiring attention as the covers of these chairs were worn or torn and this had been action required from the previous inspection
● some parts of the centre was in need of repainting for example, walls in the kitchen, stores room and some bedroom corridors required repainting as they had been marked by furniture or damaged by friction from beds and other equipment.

Judgment:
Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

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:
Overall the were suitable arrangements in place in relation to health and safety management. There was a risk management policy as set out in schedule 5 of the regulations and included the requirements of regulation 26(1). The policy covered the identification and assessment of risks and the precautions in place to control the risks identified. There was a risk register available in the center which covered for example, risks such as residents' falls, fire safety risks and manual handing risks. Clinical risk assessments were undertaken, including falls risk assessment, assessments for dependency and assessments for pressure ulcer formation. All accidents and incidents were recorded in the computerized care planning system and submitted to the person in charge, and provider representative. The inspector noted that there was evidence of suitable actions in response to individual incidents. There was recorded information/communication with relevant persons such as the person in charge, the residents' GP, next of kin, the clinical observations taken and any learning/changes required to prevent reoccurrence. The inspector noted that there was a cleaning trolley used in the centre that contained unrestricted cleaning materials and hygiene products, cloths and mops. However, the storage of cleaning liquids on this trolley required risk assessing in the context of residents with dementia potentially gaining access to such hazardous materials.

There were suitable measures in place to control and prevent infection, including arrangements for the segregation and disposal of waste, including clinical waste, and staff spoken with had received infection control training. There were adequate supplies of latex gloves and disposable plastic aprons and inspectors observed staff using alcohol hand gels, which were available throughout the centre. There was a fire safety register and fire training for staff was up to date. Staff with whom inspectors spoke confirmed their attendance at such training and their understanding of fire procedures. The communal areas and bedrooms were found to be clean. However, there were a number of infection control issues including:
● the storage of soiled laundry required review in the context of residents with dementia as it was noted to be stored in an open container on a corridor
● the lifting slings for use with lifting hoists were not individualized therefore potentially compromising the prevention of cross contamination
● the kitchen required a deep cleaning as the inspector noted that there were areas between for example, the space between the chiller and oven and, the cooker hood were not clean
● the floor in the kitchen had been painted however, this paint was noted to have chipped off in places making effective cleaning difficult.

The inspector noted that there were fire notices and fire plans located at the entrance

and on the bedroom corridors. Service records in relation to fire fighting equipment were up to date and routine checks of such equipment had been recorded. The inspector noted that there was a annual fire safety review report completed for 2017 however, it was unclear if any remedial action was required as the action plan section of this report viewed by the inspector had not been completed and was blank. There was fire safety training provided by an outside fire safety instructor, with the most recent training recorded as provided in April 2018. All staff spoken to demonstrated an appropriate knowledge and understanding of what to do in the event of fire. There were fire policies and procedures that were center-specific. However, the inspector noted that most but not all staff had received training in fire safety. There were fire safety notices for residents, visitors and staff appropriately placed throughout the building. The inspector examined the fire safety register which detailed services and fire safety tests carried out. Fire fighting and safety equipment had been regularly tested, the fire alarm and the emergency lighting was last tested in February 2018. All staff spoken to stated that they had participated in a fire evacuation drill in the center. The person in charge outlined how fire evacuation drills were practiced regularly in the center with the most recent completed in February 2018. Staff spoken to knew the evacuation requirements for each resident. However, the fire drill records required improvement to ensure that they recorded the fire scenario being simulated during the practice. This record would help facilitate effective fire evacuation practice and learning to occur during such drills. The inspector was informed that residents' personal emergency evacuation plans (PEEP's) had been completed for each resident living in the center. However, the inspector noted the PEEP's required review to ensure that they recorded the supervision level of residents after they were evacuated.

Judgment:
Non Compliant - Moderate

Outcome 08: Governance and Management

Theme:
Governance, Leadership and Management

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

Findings:
There was a clearly defined management structure in place which identified the management arrangements and accountability structures included arrangements for out of hours and at weekends. The person in charge was suitably qualified and demonstrated adequate knowledge and understanding of the Regulations and the National Standards, as well as clinical knowledge to ensure suitable and safe care. She was engaged in governance, operational management and administration associated with her role and responsibilities. There was evidence that the person in charge had a commitment to her own continued professional development and had undertaken post graduate training in relevant education and on-going training. Since the previous

inspection, there had been a change to the person in charge. The inspector noted that the current person in charge had previously been the operations manager in the centre and had also previously fulfilled the role of person in charge in this centre, for a number of years.

The person in charge confirmed that she had daily informal meetings and regular formal meetings with the provider representative, and minutes were maintained for the formal meetings. The inspector was provided with copies of the minutes of these meetings and noted that they were focused on a number of issues including matters such as residents, complaints, staffing, health and safety issues, and building renovation/maintenance. In addition to the provider representative and the person in charge, there were also two clinical nurse managers available to provide management and clinical support. Staff and residents were able to identify who was in charge and what the lines of accountability were. Over the course of this inspection, the person in charge, the provider representative and the clinical nurse manager made themselves available to the inspector and attended the feedback meeting at the end of the inspection.

There was evidence of quality improvement strategies and monitoring of the service. The person in charge provided a copy of the annual report into the safety and quality provided in 2017 which included an quality improvement plan for 2018. There was a system of audit in place, capturing a number areas, to review and monitor the quality and safety of care and the quality of life of residents. For example, there were audits in relation to medication management, food and nutrition, safeguarding and safety, residents rights, privacy and dignity, wound care and care planning. The inspector saw that action plans were put in place to support continuous quality improvement and the results of these audits were shared with staff at team meetings. However, improvements were required in relation to ensuring management systems were appropriate, consistent and effectively monitored in the centre. For example, some of the improvements identified during this inspection had already been identified and recorded as requiring action in the centres' audits. However, the inspector noted that a number of these actions had not been implemented. In addition, seven of the 14 actions required from the previous inspection as evidenced in this report, had not been satisfactorily progressed. This issue was discussed with both the person in charge and the provider representative during the feedback meeting.

Judgment:
Substantially Compliant

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 report[1]

Centre name:	Rockshire Care Centre
Centre ID:	OSV-0000688
Date of inspection:	11/04/2018 and 12/04/2018
Date of response:	21/05/2018

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 01: Health and Social Care Needs

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care including completion of oral care plans, in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

1. Action Required:

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

Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

Please state the actions you have taken or are planning to take:
Care plans are now audited by the PIC and senior nurse to ensure compliance and to give evidence of appropriate care. All residents who have been assessed as needing oral care, a plan of care is now in place.

Proposed Timescale: 10/05/2018

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
To offer choice to each resident at mealtimes including residents with a dementia.

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

Please state the actions you have taken or are planning to take:
Residents with dementia who may not be able to verbalise what they would like for a meal will be presented with a pictorial menu which they can choose what they would like for their meal on the following day.

Proposed Timescale: 01/06/2018

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
To store all medicinal products dispensed or supplied to a resident including controlled drugs in accordance with current guidelines and legislation securely at the centre.

3. Action Required:
Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

Please state the actions you have taken or are planning to take:
The checking of controlled drugs has been raised at the first nurses meeting with the new PIC and they have been informed that this is not acceptable practice. We have also brought in a new checking register which is pre-printed and a lot clearer.

Proposed Timescale: 10/05/2018

Outcome 05: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Ensure that staff have access to appropriate training including training in the use of restraints, behaviours that challange and dementia care.

4. 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 restraints trainer has begun to train the staff who have not had previous training and also providing updates to those that have been trained more than 2 years ago. Dementia training is being sourced from an external company and they have been approached to train staff in De-escalation training which a member of staff attended and felt it was appropriate for all staff.

Proposed Timescale: 01/09/2018

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
To ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

5. Action Required:
Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

Please state the actions you have taken or are planning to take:
The centre is being reviewed to reduce the noise. Already we have utilised the upstairs parlour and several residents use that area during the day and find it a comfortable and cosy space, this has also reduced the noise considerably.
We are also looking at ways of dividing the day space downstairs in the main dayroom to make areas that are homely. We have added large hangings to the wall in the

smaller room to reduce the and absorb the noise level also.
The PIC is looking at the ways in which we can improve the dining room space, by adding furnishings that will make it more homely, while also absorbing some of the noise.

Proposed Timescale: 01/10/2018

Theme:
Effective care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
To provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

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

Please state the actions you have taken or are planning to take:
The door closer on the staff room door will be adjusted to a slow the pace of the closing door to reduce the associated noise.
The chairs are being sent to an upholsterer to be recovered with more appropriate materials.
The centre is being painted as rooms become vacant on a scheduled basis.

Proposed Timescale: 01/09/2018

Outcome 07: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
To ensure that the risk management policy set out in Schedule 5 includes all requirements of Regulation 26(1) including the risk assessment of the storage of cleaning materials on the cleaning trolley.

7. Action Required:
Under Regulation 26(1) you are required to: Ensure that the risk management policy set out in Schedule 5 includes all requirements of Regulation 26(1)

Please state the actions you have taken or are planning to take:
A new risk assessment has been introduced to take into account the storage and use of the cleaning trolley (attached)

Proposed Timescale: 16/05/2018

Theme:
Safe care and support

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

8. 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:
The storage of soiled laundry has been reviewed and a new contractor is being trialled who will provide better containers for soiled linen. We will also identify a manner in which to keep the containers where residents will not have access.
Hoisting slings will be individualised for those Residents that have been assessed as requiring same.
The kitchen will be a part of the cleaning audit and also deep cleaned. We are currently getting quotes to recover the floor which will make it easier to clean.

Proposed Timescale: 01/10/2018, Audit 15/06/2018.

Proposed Timescale: 01/10/2018

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
To make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

9. Action Required:
Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

Please state the actions you have taken or are planning to take:
Staff will be trained in evacuation techniques during fire drills and scenarios will also be added to the documentation to include types of fire different locations and different times of day.

Proposed Timescale: 01/09/2018

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
To make adequate arrangements for reviewing fire precautions.

10. Action Required:
Under Regulation 28(1)(c)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

Please state the actions you have taken or are planning to take:
The fire safety report has now been completed and actions noted to improve the precautions

Proposed Timescale: 16/05/2018

Theme:
Safe care and support

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

11. 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:
This training is a part of the staff induction. Staff will be given a questionnaire to ensure their understanding.

Proposed Timescale:

Outcome 08: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
To put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

12. 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:
All audit findings and actions will be discussed at management meetings and outcome dates will be set to ensure actions are completed. This will be a standing agenda item at each management meetings where decisions will be made and recorded.

Proposed Timescale: 01/06/2018