Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Rushmore Nursing Home
Name of provider:	Rushmany Nursing Home Limited
Address of centre:	Knocknacarra, Galway
Type of inspection:	Unannounced
Date of inspection:	19 August 2021
Centre ID:	OSV-0000381
Fieldwork ID:	MON-0033997

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Rushmore Nursing Home is a purpose built facility located near Salthill, Co Galway. The centre admits and provides care for residents of varying degrees of dependency from low to maximum. The nursing home is constructed over two floors with lift access for residents. Resident bedrooms are single and double occupancy. The provider employs a staff team consisting of registered nurses, care assistants, housekeeping and catering staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	24

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 19 August 2021	09:00hrs to 17:00hrs	Una Fitzgerald	Lead
Thursday 19 August 2021	09:00hrs to 17:00hrs	Sean Ryan	Support

What residents told us and what inspectors observed

Overall, the inspectors found that the residents living in Rushmore Nursing Home received good quality health and social care that supported residents to maximise their independence with the support of a team committed to delivering person-centred care. Residents who spoke with the inspectors said that it was a nice place to live and that staff were kind, caring and treated them with respect. The only source of dissatisfaction voiced to inspectors on the day of inspection was that there was no choice offered to residents for the main course at dinner time.

This unannounced inspection was carried out during the COVID-19 pandemic. On arrival to the centre, inspectors were met by the person in charge who guided inspectors through the centres infection, prevention and control procedure such as temperature checking and hand hygiene. At the time of inspection no resident in this centre had had a COVID-19 positive test. All residents that had consented to receive the vaccination had received same.

Following an opening meeting, the inspectors walked around the centre with the person in charge. Residents were observed moving about unrestricted. Some residents were observed to be sitting out in communal areas while others were watching television or reading in their bedrooms. Some residents were preparing to attend mass while others were in the dining room having breakfast. It was evident that the person in charge was well known by residents as they greeted one another. The person in charge introduced the inspectors to the residents and explained why they were present in their home.

Inspectors spoke with multiple residents and a small number of their relatives. Some residents had lived in the centre for many years and were happy with the care they received. Residents confirmed that they knew the staff well and felt comfortable speaking to them about any concerns they may have. Residents confirmed they knew the management team well and they were a visible presence in the centre. Some residents said they go to the local shops when they wished and they were supported to maintain links with their community.

There are two communal day rooms available for residents, a dining room, a visitors room and a separate oratory. There were small seating areas off the main corridors that were pleasantly decorated and inviting to sit and relax. There was art work on display along all public corridors that gave the centre a homely feeling. Overall, inspectors observed that the premises was clean and well laid out to meet the needs of the current residents. The centre was bright and decorated to a good standard. Furnishings were bright and well maintained. Some areas of the premises required maintenance along skirting boards, door frames and doors where mobility aids had chipped paint. Some specialised seating for residents required repair where the fabric had torn on foot rests.

The dining room was bright and well laid out. The provider had installed a self

service area for residents to prepare breakfast and snacks. This was accessible at all times. The dining room was small in size but two meal sittings were provided to ensure that any resident that wished to attend the dining room could do so comfortably. Residents were also supported by staff in the dining room and the atmosphere was calm and relaxed.

Residents were complimentary of the food they received and confirmed to inspectors that there were snacks and drinks available to them throughout the day. Inspectors observed the dining experience of residents and observed it to be a social experience that residents enjoyed. However, inspectors observed that the menu on display in the dining room and the menu displayed on the corridor did not match. Inspectors also observed that the food choices listed on the daily menu were not available. For example, one menu specified Irish stew or fish but neither were available on the day. Some residents informed inspectors that they are often not provided with a choice for their main meal and must wait and see what is served. This was brought to the attention of the management team who committed to implementing their weekly menu system. Further improvement was required in the availability and choice of foods for residents with dysphagia as inspectors observed foods prepared that did not take account of all residents textured dietary requirements.

At the time of inspection, the centre had completed the installation of two en suite bathrooms in two former twin bedrooms that were now single bed occupancy. Where windows were once present, these had been replaced with patio doors to allow residents access to the garden from their bedroom. This work had been completed to a high standard but there were some minor external works outstanding around the newly installed doors that was scheduled to be addressed in the days following the inspection.

Residents bedrooms were clean, bright and personalised. Some residents had a view of the secure gardens that were well maintained. There was ample external seating for residents to enjoy the garden. This area also contained raised flower and vegetable beds.

Resident meetings were held and records reviewed showed a high attendance from the residents. There was good evidence that residents were consulted with on changes to the visiting arrangements in line with national guidance. Inspectors spent time listening to residents and family experiences of living through the COVID-19 pandemic and the challenges this presented when restrictions were in place. Inspectors acknowledged that the COVID-19 pandemic had been difficult on residents and staff. Residents complimented the staff and management team for keeping them safe from COVID-19 and although some were fearful of the virus, they felt safe knowing staff were doing their best to protect one another. Residents confirmed to inspectors that they were kept up-to-date with the changing guidance on visiting in the centre.

There was one main entrance into the building. The front door was locked by means of a keypad. The management team advised that residents could come and go at any time and that a member of staff was always available to open the door. The

code to the door was not displayed to residents. This was discussed with the management team during the inspection. The management team committed to review this practice and were in agreement that the code for the door could be given to any resident who wished to go outside, subject to them having sufficient awareness and capacity to be safe while doing so. The only other locked doors in the centre were those that were reserved for use of staff or for the purposes of storing medications, laundry or cleaning materials.

The next two sections of the report present the findings of this inspection in relation to the capacity and capability in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

Overall, inspectors found that residents received a good standard of direct care that met their assessed needs. The governance and management of the centre was sufficiently resourced. The provider had a strong presence in the centre and was committed to quality improvement that would enhance and improve the daily lives of the residents. Non compliance found with regulations on the day of inspection where possible were addressed immediately; examples of which are identified throughout the report. Notwithstanding this, improvements were required in the systems in place that ensure effective oversight of monitoring of the service provided. This was evidenced by:

- Recruitment practices to ensure all staff have a Garda Vetting disclosure on file prior to commencing employment.
- The auditing system in place did not capture the gaps in documentation found during this inspection.
- The system of risk management required development. While there was a detailed policy in place the risk register reviewed by inspectors required updating.
- Staff records reviewed had multiple gaps.
- The annual review of the service did not contain any detail and there was no quality improvements identified. There was no evidence that residents had been consulted with.
- On the day of inspection, residents were not offered a choice for their main meal. In addition, the displayed menu did not correspond with the one option being served on the day.

Rushmany Nursing Home Limited is the registered provider of the centre. This was an unannounced risk inspection to monitor the centres compliance with the regulations. The centre is registered to accommodate 26 residents in both single and double-occupancy bedrooms. The registered provider had undertaken a programme of works to install en-suite facilities in two bedrooms which subsequently reduced the occupancy of from accommodating two residents to single bed accommodation.

This had resulted in an overall reduction in registered bed capacity to 24. The inspectors acknowledge the changes had enhanced the service provided to residents. However, an application to vary a condition of registration had not been submitted.

There was a clearly defined management structure. On the day of inspection, there were 24 residents accommodated in the centre. Inspectors reviewed the staffing rosters and found that the number and skill mix of staff on duty was appropriate to meet the needs of the residents. The staff providing direct clinical care to the residents consisted of one registered nurse on duty at all times who reported directly to the person in charge. The nurse was supported by a team of healthcare assistants and the centre had catering and housekeeping staff on duty daily. Activities were provided Monday through to Friday by the activities coordinator and healthcare staff provided activities at the weekend. The staffing levels were aligned with those detailed in the centres statement of purpose and function. The person in charge confirmed that staffing levels had been maintained despite the reduction in registered beds and this had a positive impact on the care residents received.

Staff were provided with ongoing training and development relevant to their role and responsibilities. Inspectors reviewed the training records for staff and observed that all staff had received mandatory training in safeguarding, fire safety, manual handling and infection, prevention and control. Staff were knowledgeable regarding the procedure to take in the event of fire alarm activation, safeguarding of vulnerable people and the procedure to take should a resident or staff be suspected or confirmed with COVID-19. The system to ensure appropriate staff supervision in place required review. The documentation in staff files had multiple gaps and was not consistently recorded. For example, gaps in the recording of staff induction and ongoing performance reviews.

There was evidence of frequent staff meetings taking place. Although the management team worked closely and communicated daily on a range of issues, there was no formal governance and management meetings available for inspectors to review. There was a system of auditing in place to monitor the quality of the service provided. However, Inspectors found that the audit system in place for monitoring the quality of care provided and the quality of the service were not effective as they had not identified deficits such as poor medication management practices, the lack of choice provided to residents at mealtime and poor record management and documentation.

Inspectors were satisfied that complaints were managed in line with the centres complaints policy. The complaints procedure was displayed at the reception area in the centre. Following a discussion with the person in charge, the location of the procedure was changed to ensure it was prominently displayed for all residents and visitors to view. Additionally, the person in charge displayed the procedure in larger text to assist residents who may have a visual impairment. A complaints log was maintained and was observed to contain all the information as required by the regulation. There were no open complaints on the day of inspection and closed complaint records had clearly documented the satisfaction level of the complainant. Residents were aware of the complaints procedure and told inspectors they would

not hesitate to raise a concern or complaint with a member of staff. Residents were confident that any issue raised would be resolved promptly.

Regulation 15: Staffing

The number and skill mix of staff on duty during the inspection was appropriate to meet the assessed needs of the current residents in line with the centres statement of purpose and function. There is a minimum of one registered nurse on duty at all times.

The person in charge confirmed to inspectors that the reduction in registered beds had not resulted in a reduction in staffing levels. Inspectors observed that this had a positive outcome for residents in the centre.

Judgment: Compliant

Regulation 16: Training and staff development

On the day of inspection, training records provided to inspectors for review evidence that all staff had up to date mandatory training in safeguarding, fire safety and manual handling. Staff had also completed training relevant to infection, prevention and control.

Judgment: Compliant

Regulation 21: Records

Record-keeping and file-management systems required review to ensure records were appropriately maintained.

- Staff files were not maintained in line with regulatory requirements. For example, a staff member had commenced employment in the centre in advance of having a valid Garda vetting disclosure on file.
- Records of performance appraisals for staff were not consistently maintained. For example, three out of four registered nurse files reviewed had not had a formal appraisal completed.
- While risk assessments for the use of bedrails were in place, in some instances the risk had not been reassessed since 2020.
- The risk register given to inspectors was dated 2018. Not all risk identified on this inspection were identified on the register. For example, the risk

associated with one nurse on duty.

Judgment: Not compliant

Regulation 23: Governance and management

While it was evident that direct care was delivered to a high standard, inspectors found that further development of management systems in place to monitor the overall quality and safety of the service require further strengthening. For example:

- An annual review of the service was not available on the day of the inspection.
- The provider had reduced the bed occupancy in the centre and had not submitted a application to vary the conditions of registration.
- The auditing system in place was inadequate. Audits reviewed were a list of yes/no questions and there was no detail of the findings recorded. This meant that gaps were not been identified through the auditing system.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge was aware of the requirement to submit notifications to the office of the Chief Inspector.

Judgment: Compliant

Regulation 34: Complaints procedure

Complaints were managed in line with regulatory requirements and the centres policy and procedure. Residents confirmed to inspectors that they were aware of the complaints procedure and felt able to raise a concern or complaint with a member of staff. Inspectors reviewed the complaints log and found that:

- an accountable person took responsibility for resolving the complaint and complaints concerns were acknowledged.
- the actions taken on foot of the complaint were documented
- the complainants satisfaction was recorded with the outcome of the complaint.

Judgment: Compliant

Quality and safety

Overall, inspectors found that residents living in the centre received a good standard of care and support that took account of their individual needs, preferences, autonomy and promoted their independence. As previously stated, systems in place to monitor, evaluate and improve the service provided required improvement to ensure they were effective in identifying deficits and implementing quality improvements to achieve best outcomes for residents. Under this section the systems that require review where fire precautions, medication management and food and nutrition.

Each resident had a comprehensive assessment completed prior to admission to identify their care needs using a variety of validated assessment tools. This included assessment of dependency needs, falls risk, nutritional risk, social assessment and risk of impaired skin integrity. Some improvement was required to ensure that assessments were completed using the most accurate information available such as using recent resident weights to complete nutritional risk assessments. Care plans were developed in consultation with the resident and/or their family members and the staff had access to these care plans which guided the person-centred care provided. Inspectors reviewed a sample of four resident files. In the main, care plans were found to be person-centred and included personal information such as visiting preferences in the context of the pandemic. However, some room for improvement was identified to ensure that identified clinical needs were updated into the relevant sections of the care plan. For example; the requirement to administer crushed medication to a resident with dysphagia.

Medication was securely stored in a locked cupboard in the centre. Inspectors observed medication management practices that did not comply with professional regulatory requirements, guidelines or the centres own policies. Medication records did not contain the required information to support safe medication management practices such as a prescription. Inspectors observed some medications held in the centre without a prescription and these were removed by the person in charge once brought to their attention.

Residents had access to their general practitioner (GP) throughout the pandemic through a blend of remote and face to face consultations. Resident that required referral to allied healthcare professionals were facilitated to attend appointments through a similar system. Residents records evidenced that regular physiotherapy visits and reviews were occurring, referral to psychiatry of later life was provided and dietitian services were accessed where there was a concern regarding residents nutritional needs. There was evidence that any changes to a residents treatment plan were discussed in detail with the residents and/or their family and updated into the residents care plan.

Staff were knowledgeable regarding residents individual needs in terms of managing and supporting residents with responsive behaviors. A restrictive practice register was maintained in the centre and residents that requested the use of bedrails had a supporting risk assessment completed, consent forms and monitoring of safety completed. Bedrail risk assessments were reviewed by inspectors and some risk assessments require review and updating. This is actioned under regulation 21: records.

Residents' lives had been significantly impacted by the COVID-19 pandemic and consequent restrictions. Three staff had tested positive for COVID-19 during the pandemic and no residents had tested positive for COVID-19. The management team were committed to ensuring all reasonable measures were in place to prevent introducing the COVID-19 virus into the centre. This included:

- a temperature and COVID-19 symptom check on arrival to the centre and again midway through the day.
- alcohol hand sanitizers were available throughout the centre.
- An automated hand hygiene station
- appropriate signage was in place to prompt all staff, visitors and residents to perform frequent hand hygiene.
- Cleaning stations strategically placed throughout the centre to clean frequently touched surfaces.
- Staff uniforms were laundered and supplied on site
- Individual resident slings for manual handling purposes.

Inspectors observed staff practice on the day of inspection and found staff adhered to national guidelines in relation to hand hygiene, maintaining social distancing where possible and in the use personal protective equipment (PPE). The centre was found to be clean throughout and the cleaning procedure was observed to be in line with national guidance.

Residents' bedrooms were personalised with items of significance to each resident and there was adequate storage facilities in residents' bedrooms for storage of personal possessions. The laundry facilities and procedure were managed appropriately to ensure residents clothing was managed with care and minimised the risk of clothing becoming misplaced. Residents' laundry was managed on-site and each item of clothing was subtly marked for identification.

The provider had completed work on fire doors and also completed weekly fire drills within the centre. Records documented the scenarios created and how staff responded. Staff spoken with were clear on what action to take in the event of the fire alarm being activated. Each resident had a completed personal emergency evacuation plan in place to guide staff. However, inspectors found that further improvements are required to bring the centre into full compliance with the regulations. The detail is outlined under regulation 28 Fire precautions.

Inspectors observed that visiting had resumed in the center and this was in line with current national guidance. Many residents had external door access to their bedrooms to access the secure garden area and some visitors could visit residents

without the need to enter the nursing home. The person in charge confirmed that all visitors had COVID-19 monitoring checks prior to visiting whether internally or externally.

Residents rights were promoted in the centre and residents were encouraged to maximise their independence with support from staff. Residents were observed to be engaged in activities throughout the day. Residents were familiar with the activity schedule on display and could choose what activity they wanted to attend or could choose to remain in their bedroom and watch T.V or chat with staff. One resident invited the inspector to attend an exercise class that was commencing shortly after breakfast finished. The resident attended this class everyday to preserve his mobility. Residents were observed to be supported in maintaining their individual style and appearance and complimented staff for providing this support. Residents had access to religious services and attended mass in the centre with the priest on the day of inspection. Some residents had telephones in their bedrooms which were used frequently to make and receive calls from family and friends.

Regulation 11: Visits

Residents were supported to maintain personal relationships with family and friends. The centre was facilitating visiting in line with the current COVID-19 Health Protection and Surveillance Centre (HPSC) guidance on visits to long term residential care facilities.

Some residents had private access to the garden area through a secure door in their bedrooms. Residents complimented this feature as they could enjoy the garden at their leisure of welcome visitors to their bedroom while adhering to current visiting guidelines.

Judgment: Compliant

Regulation 12: Personal possessions

Residents were provided with appropriate storage in their bedrooms for personal possessions and were encouraged to personalise their private space with items of significance to each resident.

Residents clothing was laundered on-site and the laundry system in place minimised the risk of items of clothing becoming damaged or misplaced. Residents were satisfied with the service provided.

Judgment: Compliant

Regulation 18: Food and nutrition

Improvements were required to ensure each resident's needs in relation to nutrition were met and that residents were provided with variety and choice at mealtimes. Residents were not provided with a choice for their lunch on the day of inspection and the meal offered did not correspond with the menu on display.

Communication with catering staff required improvement to ensure that all staff were aware of residents individual needs and preferences in terms of modified diets.

Judgment: Not compliant

Regulation 26: Risk management

The risk policy contained all of the requirements set out under Regulation 26(1). The non compliance found with the system of risk management is actioned under Regulation 23 Governance and Management.

Judgment: Compliant

Regulation 27: Infection control

On the day of inspection, infection, prevention and control practices were observed to be of a good standard.

- the premises and equipment used by residents appeared to be cleaned and there was evidence of cleaning after each use.
- the procedure for cleaning was in line with national guidance and best practice.
- staff had access to personal protective equipment (PPE) and were observed to apply and remove PPE in line with national guidance.
- staff had access to hand hygiene sinks and automated alcohol gel dispensers were placed throughout the building.

Judgment: Compliant

Regulation 28: Fire precautions

A range of simulated fire drills had taken place. However, a simulated drill of the largest compartment taking in to consideration staffing levels and residents needs was required. This will provide assurance that their evacuation strategy could be managed in a timely manner. This was requested on the day of inspection. Once completed this will be submitted to the Office of the Chief Inspector.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Inspectors reviewed a sample of resident's medication kardex and medication administration records and observed that medication management practices did not comply with professional regulatory requirements, guidelines or the centres own policies. For example,

- the transcription of medication by nurses was not in line with professional regulatory requirements or the centres own policy and procedure.
- Medication was administered in an alternative form in the absence of a directive from the general practitioner or pharmacist.
- Medications were being kept on-site without a valid prescription.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Residents care plans were developed upon admission and formally reviewed at intervals not exceeding four months.

Care plans were informed through assessment using validated assessment tools that assessed, for example, residents dependency, risk of falls, risk of malnutrition, skin integrity a social assessment that gathered information on the residents hobbies, likes and dislikes. Where a resident had been reviewed by an allied health care professional, updates to the care plan were evident. While some gaps had been identified in the documentation inspectors were satisfied that they had been addressed by the end of the inspection.

There was evidence of resident and family involvement in the care planning process.

Judgment: Compliant

Regulation 6: Health care

Resident were provided with timely access to their General Practitioner (GP) and allied health care professionals (AHP) such as physiotherapy, dietician and speech and language therapy through a blend of face-to-face and remote consultation.

Recommendations made by AHP were seen to be implemented in consultation with the resident and their family. For example, following a fall a resident had an individualised exercise plan developed by a physiotherapist and implemented by staff that had contributed to the recovery of the residents mobility.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Inspectors reviewed files and found that residents that exhibited responsive behaviors received care that supported their physical, psychological and social care needs

Resident that required the use of bedrails had consented to their use and the appropriate risk assessment and supporting documentation was in place. Some risk assessments required updating and review and this is actioned under regulation 21: records.

Judgment: Compliant

Regulation 9: Residents' rights

Interactions between residents and staff were observed to be kind, dignified and respectful. Residents were encouraged to exercise choice and had control over how they spend their day and their right to privacy was upheld. The provider had made further improvements to the centre by adding two ensuite facilities to bedrooms to support residents privacy and residents expressed their satisfaction with this addition.

Residents were supported to maintain their individual style and appearance. Residents had the choice to participate in a variety of activities or spend time in their bedrooms reading, watching television or browse the internet. Residents were observed using a self catering area in the dining room to have a snack and drink.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Rushmore Nursing Home OSV-0000381

Inspection ID: MON-0033997

Date of inspection: 19/08/2021

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: 1 As per regulation 21, all staff employed in Rushmore nursing home has a valid garda vetting disclosure. Completed: 20/8/2021 2 As per regulation 21, all staff performance appraisals to be reviewed and formal appraisals for all staff to be completed. To be completed by: 30/10/21 3 Risk assessments for the use of all bedrails are reassessed. Completed: 10/9/2021 4 The risk register dated 2018, to be updated to include new identified risks, including the risk associated with one nurse on duty. To be completed by: 30/09/21	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. A thorough annual review of service to include residents and staff input to be completed. To be completed by: 29/10/21 2. An application to vary the conditions of registration has been submitted to HIQA	

notifying the change in bed occupancy.
Completed: 30/08/21

3. A vigorous audit system will be in place which shall detail findings and in turn identify gaps in the systems.
To be completed: 12/11/21

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
1. Put a system in place where the residents will be offered a choice for their lunch each day thus ensuring the residents are provided with variety and choice at meal times.
Completed: 01/09/21

2. There has been an update face to face communication with catering staff regarding modified diets to ensure that needs and preferences are fully met and the staff are supplied with specific information for each resident with in terms modified diets.
Completed: 01/09/21

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. A simulated drill of the largest compartment taken place with lowest staffing levels. As a result of this a management decision was made to half the biggest compartment to make two smaller compartment and this work has to be completed.
To be completed by: 05/11/21

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
1. Transcription of medication by nurses has been updated to adhere to the centres own

policy and procedure
Completed: 30/08/21

2. All medicines altered in form, will be only given under the directive of General practitioner or pharmacist
Completed: 30/08/21
1. All the medications kept on site without a valid prescription has been removed and regular checking system commenced to ensure that no medications shall be kept on site without a valid prescription
Completed: 20/8/21

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Substantially Compliant	Yellow	01/09/2021
Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.	Not Compliant	Orange	01/09/2021
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and	Not Compliant	Red	20/08/2021

	4 are kept in a designated centre and are available for inspection by the Chief Inspector.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	12/11/2021
Regulation 23(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.	Substantially Compliant	Yellow	29/10/2021
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is	Substantially Compliant	Yellow	05/11/2021

	reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Not Compliant	Orange	30/08/2021
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and	Not Compliant	Orange	20/08/2021

	will ensure that the product concerned can no longer be used as a medicinal product.			