### Centre name:
Rushmore Nursing Home

### Centre ID:
OSV-0000381

### Centre address:
Knocknacarra, Galway.

### Telephone number:
091 523 257

### Email address:
rushmorenursinghome@eircom.net

### Type of centre:
A Nursing Home as per Health (Nursing Homes) Act 1990

### Registered provider:
Rushmany Nursing Home Limited

### Lead inspector:
Una Fitzgerald

### Support inspector(s):
None

### Type of inspection
Unannounced Dementia Care Thematic Inspections

### Number of residents on the date of inspection:
24

### Number of vacancies on the date of inspection:
3
**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 ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times
From: 04 September 2018 08:30  To: 04 September 2018 17:00
05 September 2018 08:30  05 September 2018 17:00

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Provider's self assessment</th>
<th>Our Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 01: Health and Social Care Needs</td>
<td>Compliance demonstrated</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 02: Safeguarding and Safety</td>
<td>Compliance demonstrated</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 03: Residents' Rights, Dignity and Consultation</td>
<td>Compliance demonstrated</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 04: Complaints procedures</td>
<td>Compliance demonstrated</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 05: Suitable Staffing</td>
<td>Substantially Compliant</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 06: Safe and Suitable Premises</td>
<td>Substantially Compliant</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
<td>Substantially Compliant</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 08: Governance and Management</td>
<td>Substantially Compliant</td>
<td></td>
</tr>
</tbody>
</table>

Summary of findings from this inspection
This thematic inspection focused on the care and welfare of residents who had dementia. During the inspection, the centre completed the provider's 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 Standards for Residential Care Settings for Older People in Ireland (2016).

The inspector found that care was delivered to a good standard by staff who knew the residents well and discharged their duties in a respectful and dignified way. The person in charge had proactively engaged with all stakeholders to ensure that the
culture within the centre was open and transparent. The provider representative and the person in charge responsible for the governance, operational management and administration of services and resources demonstrated good knowledge and an ability to meet regulatory requirements.

The management and staff of the centre were striving to continuously improve residents’ outcomes. A person-centered approach to care was observed. Residents appeared well cared for. There was good evidence that independence was promoted and residents had autonomy and freedom of choice. Residents spoke positively about the staff. The inspector met with the residents, some of whom had advanced dementia. The inspector also spoke with family members of residents who had dementia. The feedback was very positive.

Rushmore Nursing Home is a registered designated centre that provides care for a maximum of 27 residents. On the days of inspection there was a total of five residents with a formal diagnosis of dementia and a further four residents who have symptoms of dementia. The inspector tracked the care pathways of residents with dementia and spent periods of time observing staff interactions with residents. A validated observational tool, the quality of interactions schedule -QUIS was used to rate and record at five minute intervals the quality of interactions between staff and residents. Specific emphasis focused on residents who had dementia. Documentation such as care plans, clinical records, policies and procedures, and staff records were reviewed. The centre had implemented an electronic system of capturing clinical data.

The inspector observed numerous examples of good practice in areas examined which resulted in positive outcomes for residents. The results from the formal and informal observations were positive and staff interactions with residents were patient and kind. The living environment was stimulating and provided opportunities for rest and recreation in an atmosphere of friendliness. Residents had access to outdoor gardens that were well maintained.

There were policies and procedures available to inform safeguarding of residents from abuse. Garda Vetting disclosures were in place for all staff. The centre promoted a restraint free environment. Following the last inspection the provider had delivered Safeguarding and Safety training to all staff. The registered provider had attended and completed a certificated of achievement in Advanced Safeguarding Adults and Designated Safeguarding Officer in April 2018. The inspector was concerned as the training delivered to staff had pre dated the completion of the course. This was discussed at length in the feedback meeting and the registered provider committed to delivering the training again to all staff where necessary.

The inspector followed up on the action plan from the previous inspection in December 2017, and findings indicated that two of the twelve actions from that inspection had not been adequately progressed. The inspector acknowledges that progress has been made. However, the findings of this inspection and previous inspections demonstrate that further improvements are required on the completion of the annual review of the service and staff training to bring the centre into full compliance with the regulations.
During this inspection, of the eight outcomes assessed, three moderate non-compliance and two substantial non-compliances were identified. The findings are discussed in the body of the report and improvements are outlined in the Action Plan at the end for response.
Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

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

Findings:
This outcome sets out the inspection findings relating to assessments and care planning, access to healthcare and the maintenance of records guiding practice. The centre had implemented an electronic care planning system since the last inspection. The inspector focused on the experience of residents with dementia and tracked the journey of a number of residents prior to and from admission into the centre. In addition, files were reviewed on specific aspects of care such as wound care, nutrition, mobility, access to health care and supports, medication management and end of life care.

Arrangements were in place to support communication between the residents and their families, the acute hospital and the centre. The person in charge ensured that prospective residents' needs were assessed prior to admission. The centre's management team informed the inspector that since the last inspection there is a high volume of residents been admitted for respite and short term care. The person in charge assesses the information for respite admissions over the phone to ascertain if the centre can meet their care needs. Resident who were admitted for long term care are assessed in person. This arrangement gave the resident and or their family an opportunity to meet, provide information and assess or determine if the service could adequately meet the needs of each resident.

Comprehensive assessments of the health, personal and social care needs of all new residents was carried out within 48 hours of their admission and care plans were developed accordingly. Clinical observations such as blood pressure, pulse and weight were assessed on admission and as required thereafter. The assessment process involved the use of validated tools to assess each resident’s dependency level, risk of malnutrition, falls risk and their skin integrity. The electronic system in place was designed to have all care needs assessed within a general care plan template titled “assisting residents to meet holistic needs”. In addition specialised care plans for specific needs such as management of wound care and diabetes were also in place.

Arrangements were in place to routinely evaluate existing care plans on a four monthly basis. Care plan were person-centered and detailed. The inspector found clear evidence that care plans were reviewed and updated to reflect the residents' changing
care needs. In addition, there was good records in place to evidence that care plan reviews were done in consultation with the resident and where appropriate the resident’s family.

Arrangements were in place to meet the health and nursing needs of residents with dementia. The person in charge confirmed that a number of general practitioners (GPs) were attending to the needs of residents in the centre. Residents who lived in the locality were facilitated to retain the services of the GP they attended prior to their admission to the centre. Residents' documentation reviewed by the inspector confirmed they had access to out-of-hours medical care. Community psychiatry of older age specialist services attended residents in the centre with dementia. Access to allied healthcare professionals including physiotherapy, dietetic, speech and language, tissue viability and dental services were available. There was evidence that advice received from allied healthcare professionals was acted upon in a timely manner.

There were systems in place to ensure residents' nutritional needs were met, and that they did not experience poor 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 clinically indicated. Residents’ intake and output was recorded and referenced a good level of detail including portion sizes. The person in charge had discussed fluid intake at a recent staff meeting and highlighted the importance to all care staff. There was access to a safe supply of fresh drinking water at all times.

Dining arrangements were set up in one dining room. There were two sittings to accommodate resident choice. A varied menu was provided. The inspector saw that residents had a choice of hot meals. Staff confirmed that alternatives were also available to the menu available each day if residents did not like the dishes on offer. There were arrangements in place for communicating residents' dietary needs between nursing and catering staff to support residents with special dietary requirements. Residents on specialised diets such as diabetic, fortified and modified consistency diets and thickened fluids received their correct diets and fluid consistencies. The inspector was told by the chef on duty that the menu had been subject to review by a dietitian. The menu choice was served on a three-week cycle. Residents received discreet assistance from staff with eating where necessary. The feedback from residents was very positive on the standard of food within the centre.

There were robust arrangements in place to review accidents and incidents within the centre. Residents were assessed to identify their risk of developing pressure-related skin injuries. Residents assessed as high risk had specific equipment in place to mitigate level of risk, such as repositioning regimes and pressure relieving mattresses and cushions. There were no residents with pressure ulcers on the days of inspection. There was a policy and procedures in place to guide and manage residents’ wound care. Tissue viability specialist services were available to support staff. The inspector reviewed wound management procedures that had been in place for one resident. There was good evidence that advice received was followed and that the wound was healed.

Staff provided end-of-life care to residents with the support of their GP and community palliative care services. There was no resident receiving end of life care on the days of
Residents admitted for long term care were given an end of life preparation and information document titled “Looking Ahead”. This document contained personal information relating to end of life care wishes. The resuscitation status of all residents was recorded and all nursing staff spoken to knew how to access this information in the event of a cardiac arrest. Staff outlined how religious and cultural practices were facilitated within the centre. Residents were satisfied with the arrangements in place. The centre has an oratory for resident use. Family and friends who wish to stay overnight within the centre can be accommodated.

Residents were generally protected by safe medicine management policies and procedures. There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. The storage of medicines required review as the inspector found unused medicines left in the nurses’ station. In addition nutritional supplements were also found in the main kitchen fridge. Practices in relation to prescribing and medicine reviews met with the legislation and regulatory requirements. Nursing staff were observed administering medicines to residents and practices reflected professional guidelines. Appropriate storage and checking procedures were in place for medicines controlled under misuse of drugs legislation and medicines requiring refrigerated storage.

Judgment:
Substantially Compliant

**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:**
The self assessment tool (SAT) completed by the provider was rated compliant in this outcome. During the last inspection this Outcome was judged as major non –compliant. HIQA did not agree with the action plan response submitted to address the non compliance found. The action of staff training on elder abuse is restated and outlined below.

The centre had policies dated March 2018 in place to protect residents from suffering abuse and to respond to allegations, disclosures and suspicions of abuse. The provider representative has responsibility within this centre to deliver the Safeguarding and safety training and had completed two courses in April 2018 on Safeguarding. The training records evidenced that all staff had completed elder abuse training and there was a certificate on staff files signed by the provider representative. However, the inspector noted that 27 of the staff had received the training prior to the provider having
received the certificate of achievement. Therefore, at the time the staff received the training the course trainer had not been certified as being in a position to deliver the course content. This was discussed in detail at the feedback meeting and the registered provider was in agreement to deliver the course again to all staff that received the training prior to April 2018.

The inspector spoke with multiple staff over the two days of inspection and acknowledges that staff were able to explain the different categories of abuse and had knowledge of what their responsibility is should they suspect abuse. In addition staff spoken to were clear about whom they would report any concerns too.

The centre has a policy dated July 2018 on the procedures in place to support staff in working with residents who have behavioural and psychological symptoms of dementia (BPSD). This policy was informed by evidence-based practice. On the days of inspection there was no resident who had behavioural related issues. The inspector reviewed a file of a resident who had a history of BPSD. The resident was very content and settled in the environment. Triggers and de-escalation techniques were clearly identified. During the inspection it was observed that staff approached this resident in a sensitive and appropriate manner.

The centre promoted a restraint free environment. Additional equipment to reduce the use of restraint such as low level beds and sensor alarms were available following an assessment and seen in use. The inspector reviewed the care plans of residents currently using bedrails. The care plan guided practice. A bedrails risk assessment had been completed and also had a falls risk assessment. There was evidence in one file that all other measures had been exhausted and this was documented. Care plans were reviewed at required intervals in consultation with the resident and where appropriate their family. The inspector also noted that resident's with no cognitive impairment signed their own bedrail consent form. Safety checks for residents with bedrails were in place as evidenced by the electronic system. There was no chemical restraint in use within the centre.

Systems and arrangements were in place for safeguarding residents' finances and property which met the requirements of the regulations. The accounting process was demonstrated to an inspector by staff. The procedures and processes for safeguarding residents' finances were clear and transparent. The centre is not a pension agent for any resident. Procedures were in place to facilitate residents to access their money at all times.

Judgment:
Non Compliant - Moderate

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:
Residents are facilitated to exercise their civil, political, religious rights and are enabled to make informed decisions about the management of their care through the provision of appropriate information. There are arrangements in place for each resident to receive visitors in private.

Resident meetings evidenced that residents are consulted about how the centre is planned and run. There was good resident representative at the meeting, including residents with dementia. The centre seeks feedback from resident and family via comment cards that are left at the main reception. The inspector reviewed the last ten that were received. The resident and family feedback was very positive. In addition, the centre has a resident council that meet every four months with an independent advocate in attendance. Residents can also individually access the independent advocacy services.

Residents with dementia receive care in a dignified way that respects their privacy at all times. Following on from the last inspection the activities schedule had been reviewed. Residents had opportunity to avail of a varied activity programme. Activities developed for resident with dementia formed part of this programme, and this had a positive impact on those who participated.

The inspector was informed by residents and family that all significant events are celebrated within the centre and that residents with dementia would be aware when it was Christmas, Halloween or Saint Patrick's day because of the effort put in by management and staff to decorate the communal areas. There was an emphasis on music and the inspector observed an afternoon of music that was thoroughly enjoyed by the residents that attended. The atmosphere in the room was positive, welcoming and inclusive of all. Residents sang along. The staff who were supervising the room were actively involved.

Residents' links with the local community were maintained where possible, and this was supported by access to local media and telephone services. Each resident has opportunity to participate in activities that are meaningful and purposeful to their needs, interests and capacities. Residents with advanced dementia were included in group activities. The activities staff conducted one to one activities when possible. For example, the inspector noted that individual residents were brought out for walks on a regular basis. The staff were knowledgeable on the lives and life stories of residents prior to living in the nursing home. Many of the residents were local to the area, and at the time of inspection, the centre had bunting to show support for the Galway hurling team.

As part of the dementia focus the inspector took periods of time to observe the quality of interactions between staff and residents. Staff were mostly observed speaking to residents in a polite, respectful and friendly manner, using residents' names and explaining what was happening during assistance. Choice was offered when snacks and drinks were being served. Staff and resident interactions were kind and patient. Staff
displayed good knowledge of resident likes and dislikes. In addition, staff used personal information to engage in conversation with each resident that was meaningful to them.

**Judgment:**
Compliant

---

**Outcome 04: Complaints procedures**

**Theme:**
Person-centred care and support

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

**Findings:**
There were policies and procedures for the management of complaints. The complaints process was displayed in a prominent place in the reception area. The person in charge was involved in the management of complaints received. The inspector reviewed the complaints log. Records indicated that complaints were minimal, a total of nine to date in 2018. Residents were informed on admission of the complaints procedure.

The management of all complaints received had been investigated promptly, a record of the outcome was documented and there was also detail if the complainant was satisfied with the outcome. The centre had an appeals officer and also directed the complainant to the office of the Ombudsman if unhappy with the outcome.

Residents spoken with on the days of inspection told the inspector that they would not hesitate to make a complaint if they had one. Relatives voiced satisfaction with the care and were aware of who they could complain to if they needed.

**Judgment:**
Compliant

---

**Outcome 05: Suitable Staffing**

**Theme:**
Workforce

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

**Findings:**
The inspector reviewed actual and planned rosters for staff, and found that staffing
levels and skill mix were sufficient to meet the needs of residents. Following on from the last inspection the care staff compliment on duty to attend to resident direct care needs had been increased. The person in charge monitors resident dependency and staffing levels to inform staffing levels. The person in charge had implemented a new system to improve on staff supervision. Each shift now has a team leader on duty who had responsibility for completing a daily summary sheet that is discussed at 12 midday and 7pm each day. This ensures that all information regarding any change in resident needs is communicated in a timely manner. Staff spoken to confirmed that they had sufficient time to carry out their duties and responsibilities. Residents and relatives confirmed that call bells are answered in a timely manner.

The education and training available to staff enables them to provide care that reflects up-to-date, evidenced based practice. There were no gaps identified on staff mandatory training in manual handling practices and fire training. In addition there was a member of staff on duty at all times trained to deliver cardio-pulmonary resuscitation. Evidence of current professional registration for all registered nurses was seen by the inspector. The gaps identified under Elder Abuse training are actioned under Outcome 3 Safeguarding and Safety.

Recruitment and induction procedures were in place. Staff spoken with felt supported by the management team. The person in charge was in process of carry out annual appraisals for all staff. The inspector reviewed a sample of a completed reviews which were a detailed document addressing any concerns and areas for improvement.

All documents required under Schedule 2 of the regulations are contained in the personnel files. All staff files had Garda Vetting disclosures in place.

The person in charge confirmed that there are no volunteers working within the centre.

Judgment:
Compliant

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

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

Findings:
The self assessment tool (SAT) completed was rated as substantially compliant in this outcome. The management identified that improvements are required in relation to directional and visible signage throughout the centre to guide residents. In addition, management also identified that photographs at resident’s bedroom doors could be of benefit.
Rushmore Nursing Home is registered to accommodate 27 residents on two levels. It had 17 single and five twin bedrooms. The centre did not have a dementia specific unit and residents with dementia integrated with the other residents in the centre.

The centre was found to be reasonably well maintained, warm, comfortable and visually clean in most parts. Some improvement was required in relation to the paint and decor in parts which was worn and in need of repair. Heat, lighting and ventilation were adequate and the temperature of the building met requirements in bedrooms and communal areas where residents sat during the day.

The centre has two sitting rooms, an oratory and one dining room for resident use. The largest of the sitting rooms was utilized throughout the day and was a hub of activity. This communal room was supervised by a member of staff at all times. The communal areas had a variety of comfortable furnishings and were domestic in nature. The provision of side tables was beneficial to residents in sitting rooms to support them with magazines, papers, snacks and drinks.

Handrails were available in circulation areas throughout the building, and grab rails were present in toilets and bathrooms. On the ground floor there were nine residents accommodated that shared a large assisted bathroom with shower and bath facilities. The residents in these rooms all had access to a wash hand basin in their bedrooms. This was discussed with the person in charge. The inspector was told that with the current resident care needs this shared arrangement was not a barrier to providing care. The long term solution on how to ensure that the limited availability of shower and bath facilities does not impact on future resident needs will be addressed within the action plan response. The furniture and equipment seen in use by residents was in good working condition and appropriate to their needs. Supportive equipment such as call bell facilities, remote control devices, hoists and mobility aids were seen in use by residents that promoted their independence. The inspector found that the privacy and dignity of residents was promoted in each bedroom by its layout. Many rooms were personalised with photos, memorabilia and artifacts. Some rooms had clocks or calendars to orientate residents to time and date. Each shared room had access to a locked press for personal belongings.

A review of some aspects of the layout and design of the centre required improvement to meet its stated purpose in respect of providing accommodation for residents with dementia. Additional signage, picture aids and cues were required to support residents to navigate the centre and locate their bedrooms, indoor and outdoor communal areas and bathroom facilities.

Residents had access to safe and enclosed outdoor areas with seating, paths and flower beds.

**Judgment:**
Non Compliant - Moderate

**Outcome 07: Health and Safety and Risk Management**
Theme: Safe care and support

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

Findings:
The centre had policies and procedures relating to health and safety within the centre last reviewed in June 2018. There was a health and safety statement also dated June 2018. Further review of the risk management policy was required as the policy did not include all of the requirements set out in Regulation 26(1). The centre had a current risk register that was kept under review by the management team. The register identified areas of risk within the centre and the control measures in place to minimise any negative impact on residents. The scoring to assess risk in the policy and risk register where not aligned and required review.

Arrangements, consistent with the national guidelines and standards for the prevention and control of healthcare associated infections, were in place. Staff had access to personal protective equipment such as aprons and gloves, hand washing facilities and hand sanitisers on corridors. Staff were seen using these facilities between resident contact. Signs were on display to encourage visitors to use the hand sanitisers. Some gaps were noted in the daily cleaning schedules in communal bathrooms. Residents spoken too confirmed that their bedrooms are cleaned on a daily basis. The inspector observed that the standard of cleanliness throughout the building was of a good standard.

Aspects of fire safety and risk management required improvement as they could potentially impact on the safety and welfare of residents. Weekly fire alarm checks to provide assurance that the system is functioning are not carried out. The fire alarm system was triggered during the inspection at the inspectors’ request and found to be in working order. The inspector did observe that five doors on the ground floor and one door on the first floor did not close. This fault would have been identified with weekly alarm tests. The centre management addressed the issue during the inspection and all doors were in working order by the end of inspection.

Fire safety and response equipment was provided. Fire equipment servicing for all extinguishers had not been carried out on an annual basis and was over due since June 2018. Weekly checks were carried out on all escape routes. The fire alarm was serviced on a quarterly basis. Fire exits were identifiable by obvious signage and on the days of inspection exits were unobstructed to enable means of escape. Each resident had a completed personal emergency evacuation plan in place that was easily retrieved in a timely manner. Staff spoken to were knowledgeable about fire safety and evacuation procedures. A simulated fire drill was carried out in February and August 2018. There was evidence that any areas identified that required follow up were actioned and communicated to staff. The training records identified that all staff had received annual fire safety training.
Judgment:
Non Compliant - Moderate

Outcome 08: Governance and Management

Theme:
Governance, Leadership and Management

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

Findings:
There were sufficient resources in place to ensure the effective delivery of care as described in the statement of purpose. There was a clearly defined management structure with explicit lines of authority and accountability, and the roles and responsibilities for the provision of care were clear. The person in charge facilitated the inspection process by providing documents and having good knowledge of residents’ care and conditions. There was a focus on developing a culture of quality improvement and learning to drive improvements in the standard of care delivered to residents.

The inspector noted that progress in multiple areas have occurred within the centre. Following on from the last inspection the management had completed a quality improvement plan. The centre has engaged with an external provider who has provided assistance in the development of an auditing schedule. This proposed auditing schedule and review system is awaiting implementation. Since the last inspection, clinical audits were carried out that in the areas of medicine management and care plan development. In addition a system was in place to review all incident and accidents that occur within the centre. This information was available for inspection. The person in charge is currently in progress of a full review of the Schedule 5 policies and procedures to ensure that they are centre specific and reflective of the practices in place.

The provider and person in charge work full time within the centre. The management and staff were striving to continuously improve outcomes for residents. The provider and person in charge held monthly management meetings. The meetings were minuted and were available for review. There was good evidence that discussions on all operational issues are addressed. An annual review of the quality and safety of care delivered to residents for 2017 was completed. However, this action is restated. The annual review required further development to ensure that it was used as way of seeking to improve the quality and safety of care provided that informed the service plan and identified the future quality improvement initiatives. Additionally, there was no evidence to support that the annual review was prepared in consultation with residents and their families as required under regulation 23(e).

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:**

Una Fitzgerald
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
**Provider’s response to inspection report¹**

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Rushmore Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000381</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>04/09/2018</td>
</tr>
<tr>
<td>Date of response:</td>
<td>15/11/2018</td>
</tr>
</tbody>
</table>

**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 Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The storage of medicines required review as unused medicines were left in the nurses' station. In addition nutritional supplements were also found in the main kitchen fridge.

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

¹ The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
A locked cupboard will be provided in the nurse’s station to store all medicinal products to include nutritional supplements.
A locked refrigerator in the nurse’s station will be used to store nutritional supplements if required.

Proposed Timescale: 15/11/2018

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The training records evidenced that all staff had completed elder abuse training and there was a certificate on file signed by the provider representative. However, the inspector noted that 27 of the staff had received the training prior to the registered provider having received the certificate of achievement. Therefore, at the time the staff received the training, the course trainer had not been certified as being in a position to deliver the course content. This was discussed in detail at the feedback meeting and the registered provider was in agreement to deliver the course again to all staff that received the training prior to April 2018.

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

Please state the actions you have taken or are planning to take:
Staff, requiring re-training in detection and prevention of and responses to abuse shall be completed by 15/11/2018

Proposed Timescale: 15/11/2018

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:
On the ground floor there were nine residents sharing a large assisted bathroom with shower and bath facilities. The residents all had access to a wash hand basin in their bedrooms. The long term solution on how to ensure that the limited availability of shower and bath facilities does not impact on future resident needs will be addressed within the action plan response.
Additional signage, picture aids and cues were required to support residents to navigate the centre and locate their bedrooms, indoor and outdoor communal areas and bathroom facilities.

3. 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:
Proposed Timescale: The number of residents using the shower and bath facilities shall be limited to maximum of 8. One bed shall be removed from this area. This change will be reflected in the Statement of Purpose

Suitable signage, picture aids and cues will be displayed in order to assist residents navigate throughout the nursing home.

**Proposed Timescale:** 28/11/2018

<table>
<thead>
<tr>
<th>Outcome 07: Health and Safety and Risk Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Safe care and support</td>
</tr>
<tr>
<td><strong>The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:</strong> The scoring to assess risk in the policy and risk register where not aligned and required review.</td>
</tr>
<tr>
<td><strong>4. Action Required:</strong> Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong> Policies and procedures shall be reviewed by 20/11/2018, and will reflect best practice and reflect practice in the nursing home.</td>
</tr>
<tr>
<td><strong>Proposed Timescale:</strong> 20/11/2018</td>
</tr>
<tr>
<td><strong>Theme:</strong> Safe care and support</td>
</tr>
<tr>
<td><strong>The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:</strong> Further review of the risk management policy was required as the policy did not include</td>
</tr>
</tbody>
</table>
all of the requirements set out in Regulation 26(1).

<table>
<thead>
<tr>
<th>5. Action Required:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under Regulation 26(1)(c)(iii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.</td>
</tr>
</tbody>
</table>

**Please state the actions you have taken or are planning to take:**
The risk management policy shall be reviewed to include all requirements set out in Regulation 26(1). This will include Section 5, the measures and actions to control accidental injury to residents, visitors or staff

<table>
<thead>
<tr>
<th>Proposed Timescale: 30/10/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme: Safe care and support</td>
</tr>
</tbody>
</table>

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Further review of the risk management policy was required as the policy did not include all of the requirements set out in Regulation 26(1).

<table>
<thead>
<tr>
<th>6. Action Required:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under Regulation 26(1)(c)(v) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.</td>
</tr>
</tbody>
</table>

**Please state the actions you have taken or are planning to take:**
The risk management policy shall be reviewed to include measures and action in place to control self-harm

<table>
<thead>
<tr>
<th>Proposed Timescale: 30/10/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme: Safe care and support</td>
</tr>
</tbody>
</table>

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Aspects of fire safety and risk management required improvement as they could potentially impact on the safety and welfare of residents. Weekly fire alarm checks to provide assurance that the system is functioning are not carried out.

<table>
<thead>
<tr>
<th>7. Action Required:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under Regulation 28(1)(c)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.</td>
</tr>
</tbody>
</table>

**Please state the actions you have taken or are planning to take:**
A system of Weekly fire alarm checks is implemented and is now in practice and results documented.

**Proposed Timescale:** 11/09/2018

**Theme:** Safe care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Fire safety and response equipment was provided. Fire equipment servicing for all extinguishers had not been carried out on an annual basis and was overdue since June 2018.

**8. Action Required:**
Under Regulation 28(1)(c)(iii) you are required to: Make adequate arrangements for testing fire equipment.

**Please state the actions you have taken or are planning to take:**
Following inspection the servicing of all the Fire equipment took place the next day.

**Proposed Timescale:** 06/09/2018

**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:**
An annual review of the quality and safety of care delivered to residents for 2017 was completed. However, this action is restated. The annual review required further development to ensure that it was used as way of seeking to improve the quality and safety of care provided that informed the service plan and identified the future quality improvement initiatives.

**9. Action Required:**
Under Regulation 23(d) you are required to: Ensure 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.

**Please state the actions you have taken or are planning to take:**
The annual review is now ongoing and shall be completed by year end. It shall be developed in such a way that it ascertains at ways to improve quality and safety of care provided, whilst also informing the service plan, identifying quality improvement initiatives.
Proposed Timescale: 31/01/2019

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
There was no evidence to support that the annual review was prepared in consultation with residents and their families.

10. Action Required:
Under Regulation 23(e) you are required to: Prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.

Please state the actions you have taken or are planning to take:
The annual review will reflect the participation and feedback from residents and their families. The findings of this feedback will be documented in the annual review report.

Proposed Timescale: 31/01/2019