<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Rockshire Care Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000688</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Rockshire Road, Ferrybank, Waterford.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>051 831108</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:info@rockshirecarecentre.ie">info@rockshirecarecentre.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>RCC Care Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Michael Dwyer Snr.</td>
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<tr>
<td>Lead inspector:</td>
<td>Gemma O'Flynn</td>
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<tr>
<td>Support inspector(s):</td>
<td>Ide Cronin</td>
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<tr>
<td>Type of inspection:</td>
<td>Unannounced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>35</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>3</td>
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About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider’s compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

▪ to monitor compliance with regulations and standards
▪ to carry out thematic inspections in respect of specific outcomes
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).
This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

**The inspection took place over the following dates and times**

From: 29 November 2016 08:50  
To: 29 November 2016 00:00

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
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<td>Outcome 02: Governance and Management</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 04: Suitable Person in Charge</td>
<td>Compliant</td>
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<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 08: Health and Safety and Risk</td>
<td>Non Compliant - Major</td>
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<tr>
<td>Management</td>
<td></td>
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<td>Outcome 09: Medication Management</td>
<td>Non Compliant - Moderate</td>
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<td>Outcome 11: Health and Social Care Needs</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Non Compliant - Moderate</td>
</tr>
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**Summary of findings from this inspection**

This report sets out the findings of an unannounced, one day inspection, the purpose of which was to monitor ongoing compliance with the regulations. The centre was last inspected in May 2016 and 11 actions were issued. Those actions were also followed up on to determine their progress. Of the 11 actions, nine had not been satisfactorily progressed or completed.

As part of the inspection process, inspectors met with residents, relatives, staff, the person in charge and the provider. Residents' and relatives' views were elicited, practices were observed and documentation was reviewed. Overall, residents told inspectors that they felt safe in the centre and that they were happy. However, some residents voiced dissatisfaction with the channels of communication with management. Residents were complimentary of staff and it was evident via observations that staff knew residents and their needs well. On the day of inspection interactions between staff and residents were appropriate and respectful. However, there was some evidence of a task based approach to care. Staff who spoke with inspectors demonstrated knowledge of their role and responsibilities and were able to discuss the care that they provided for residents. Residents had access to medical and allied health care as confirmed by residents, relatives and documentation reviewed.
On the day of inspection there were lots of activities in the centre, including one to one activities. Mass was celebrated, a sing song was held and a professional musician provided afternoon entertainment.

However, as stated above, actions pertaining to the previous inspection had not been satisfactorily progressed or addressed. Some identified non-compliances had also been identified on inspection in 2014 but remained an ongoing issue. Repeat non-compliances are restated throughout this report. Inspectors’ judgments of compliance are reflected in the table above and discussed in detail throughout the report.
Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 02: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management

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

Findings:
On the day of inspection there were sufficient resources to deliver effective care for residents. However, there were some issues regarding staff nurse resources which is discussed under the staffing outcome.

There was a clearly defined management structure in place and staff were able to identify the lines of accountability. The person in charge stated that management met monthly and meeting minutes reflected this. Agenda items included risk management, audit findings, complaints and resident care. Minutes for staff meetings were reviewed and agenda items included the use of restraint, incident reports, training and the daily routine of the centre. The most recent staff meetings were held in October 2016 and those previous to that were held in April 2016. Nine of the 11 actions associated with the previous inspection had not been satisfactorily progressed. The person in charge had taken up her post in August, three months prior to this inspection and was working on implementing the centre’s action plan. As discussed in the staffing outcome at the end of the report, inspectors formed the judgment that the need for the person in charge to regularly cover some nursing shifts was having an impact on implementing these actions.

There was an annual review completed for 2016 and this was available for review on the day of inspection. A risk register was due to be introduced by October 2016 and this had been completed. However, the review also stated that mandatory training was 90 per cent complete but findings on inspection contradicted this.

There was an audit schedule in place but inspectors found that audits did not always contribute to improvements in the quality and safety of care. For example, the infection control audit that had been competed in February 2016, did not have a compliance rating and there was no analysis of the data to review the findings of the audit and plan.
action if required. A wound care audit completed in March 2016 did not consider the overall approach and management of wound care in the centre. A care plan audit completed in October 2015 reviewed six care plans. While it identified deficiencies in individual care plans, it did not establish an action plan to ensure that all care plans would be of a standard that would comprehensively direct care. The person in charge stated that an audit of restraint practices had been undertaken, however she was unable to locate same on the day of inspection. After the inspection, an audit review of physical restraint that was dated October 2016 was forwarded to inspectors by the person in charge.

There was evidence of consultation with residents. Resident meetings had been held in January, April, July, September and November of 2016. There was evidence that residents were afforded an opportunity to have their say and topics such as fire safety, smoking and activities were seen to be discussed. Meeting minutes did not assign any action to suggestions or feedback from residents. The person in charge stated that the minutes from the previous meeting were discussed at each meeting and residents were updated. There was no documentation to evidence this and residents who spoke with the inspector said that they were not updated following suggestions or feedback to ensure and document that they were addressed. Some feedback to inspectors on the day of inspection indicated that the consultation process didn't capture all relevant feedback. For example, inspectors heard about resident dissatisfaction with food and drink and other feedback indicated that some residents felt that at times they weren't listened to.

**Judgment:**
Non Compliant - Moderate

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**Outcome 04: Suitable Person in Charge**
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

**Theme:**
Governance, Leadership and Management

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

**Findings:**
A new person in charge had been appointed since the previous inspection in May 2016. She had been in the post since August 2016 and was a registered psychiatric nurse with the required experience in nursing the older adult. She stated that she planned to undertake continuing professional development and said she was in the process of identifying a suitable management course and wished to also complete a course in gerontology.

She worked in the centre Monday to Friday for 36.5 hours per week.
Residents could identify her as the person in charge and staff were supportive of her as a manager, saying that she was a positive addition to the centre and was approachable if they had any concerns.

**Judgment:**
Compliant

**Outcome 07: Safeguarding and Safety**

*Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.*

**Theme:**
Safe care and support

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

**Findings:**
The actions identified on the previous inspection in May 2016 had not been satisfactorily addressed.

There was a policy in place on, and procedures in place for, the prevention, detection and response to abuse dated January 2016. However, this policy was not being fully implemented. For example, it was stated in the centre's policy, that staff would receive training on protection of vulnerable adults on a two yearly basis, the person in charge confirmed this. However, as also identified on the previous inspection, a number of staff had not received training since 2010, 2012 and mid 2014.

Staff who spoke with inspectors were able to explain the different types of abuse and clearly outline what they would do in the event of witnessed or suspected abuse. Staff were seen to interact with residents in a respectful and caring manner and residents told inspectors that they felt safe in the centre.

There was a behaviour management policy in place dated March 2015. Staff were observed assisting residents who presented with behavioural and psychological symptoms of dementia (BPSD) and interactions were sensitive and knowledgeable. Staff who spoke with inspectors were able to identify residents with BPSD and outline the interventions they would employ to support those residents. However, as identified on the previous inspection, care plans to support residents with BPSD were not comprehensive. In the sample of files reviewed, the information in the care plans was not person centred and did not outline triggers for behaviours and associated management strategies to guide safe and consistent care. Care plans did not reflect the
knowledge of the staff or the practice observed in the centre.

The person in charge discussed validated tools that were used in the centre to monitor behaviour so as to identify triggers and inform care plan development. However, these documents were not available for review on the day of inspection.

There was an effort to promote a restraint free environment and the incidence of bed rail use was low, with eight residents using same. Lap belts were in use in the centre. Records shown to inspectors demonstrated that regular safety checks were undertaken when restraint was in use. The person in charge discussed the clinical decision making process prior to the use of restraint and this involved nursing, physiotherapy and medical input, a sample of files reviewed reflected this.

There were systems in place to safeguard resident finances. These were reviewed on the day of inspection and records were accessible and transparent.

Over half of the residents in the centre on the day of inspection had a diagnosis of dementia, however, only 10 staff members had received training in dementia care. The majority of staff had received training in the management of behaviours, four staff had not received that training. For those who had received training in the management of behaviours some had received that training in 2010, 2011 and 2012.

**Judgment:**
Non Compliant - Moderate

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**Outcome 08: Health and Safety and Risk Management**

*The health and safety of residents, visitors and staff is promoted and protected.*

**Theme:**
Safe care and support

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

**Findings:**
Non-compliances identified on the previous inspection of the centre had not been satisfactorily addressed. These are restated in this outcome.

The centre had policies and procedures relating to health and safety. A risk register had been updated in October 2016. Examples of risk assessments included in the risk register were weight loss, falls, manual handling, cross infection and hand hygiene. Inspectors found that not all hazards had been identified and risk assessed, such as the residents' smoking shelter, its location and lack of safety controls such as a call bell.

Individual smoking risk assessments were not carried out for residents who smoked to
ensure that all controls necessary to ensure their safety were implemented. This was particularly pertinent given the location of the smoking shelter which was situated at the rear of the centre, out of view of staff. The provider and the person in charge stated that all residents were accompanied either by staff or family when going out to smoke, this control was referenced in the general smoking risk assessment. However, on the day of inspection, residents were observed going out to smoke unsupervised, therefore controls were not implemented. The person in charge was asked by inspectors to undertake such assessments and forward same to HIQA. This was done so within the agreed timeframe.

On the day of inspection, the centre was clean in appearance, however, a strong odour permeated both floors of the building. This was discussed with the person in charge and the provider. The provider stated that there had been recent damage to the floors in the communal areas. The inspector found that further works were required to address same. A general infection control policy for nursing homes was in place, however, this was dated 2005 and was not complemented by a local policy to provide further centre-specific guidance to staff. For example, inspectors were given conflicting information about the frequency of specific cleaning procedures. As also observed on the previous inspection, kitchen staff were not wearing appropriate personal protective equipment to mitigate risk of infection to residents.

People moving and handling training was out of date for eight staff members and over the course of the inspection, outdated and potentially unsafe moving and handling practices were observed.

On the day of inspection, all fire exits were unobstructed. Fire safety training had been carried out for the majority of staff, however, as identified on the previous inspection in May 2016 and during an inspection in May 2014, not all staff were up to date with fire safety training. For example, on this inspection, three staff were awaiting training, another staff member had not received training since 2012 and another since 2014. Most staff who spoke with inspectors knew what to do in the event of the fire alarm sounding, however, not all staff were able to explain the full procedure to follow in the event that the fire alarm was activated. The person in charge was informed of this on the day of inspection.

There were personal emergency evacuation plans in place for residents. The last fire drill had taken place in November 2016 and comprised six staff. The fire drill documentation demonstrated that staff were asked questions to demonstrate knowledge on what to do. While this is good practice, more detailed documentation was required to demonstrate that the arrangements for evacuating residents were sufficient. For example, the person in charge did not know how long it would take to carry out a horizontal evacuation of a compartment in the centre if required.

Staff who spoke with inspectors said that drills were carried out, however, evacuation or simulated evacuations did not form part of the drill. The drill stopped once the ‘fire’ had been located. Fire drill attendance records indicated that not all staff had participated in a drill as also identified on the previous inspection. There was no documented information as to the time of drill, the length of time it took staff to respond or complete an evacuation. There was no record of what the drill consisted of, what went well and
what required improvement. This was discussed with the provider and person in charge at the feedback meeting.

Judgment:
Non Compliant - Major

Outcome 09: Medication Management
Each resident is protected by the designated centre’s policies and procedures for medication management.

Theme:
Safe care and support

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

Findings:
Issues identified on the previous inspection relating to medication management had been addressed, however, on this inspection, a number of other non-compliances were found.

There were written operational policies in place for medication management dated September 2016. However, on review of medication administration documentation, a number of deficiencies were noted. For example, there were omissions in the signature field of the medication administration record, therefore, in the sample of files reviewed inspectors were unable to ascertain as to whether or not residents had received their medication as prescribed. There were numerous omissions in the recording of daily medication refrigerator temperatures.

Transcribing practices were in use in the centre and on the day of inspection this practice was seen to be in line with current best practice guidance.

The management of controlled medications was reviewed and was compliant with current guidance for nurses. A random check of stock balance for two residents tallied with records.

Medications that required crushing were seen to be prescribed as such on this occasion, this was an action following the previous inspection.

Medication management was subject to audit, the most recent being August 2016. However, it was not evident that audits elicited meaningful information to ensure improvement in practices as audits did not determine a level of compliance. There were no timeframes for completion of any actions required nor was a responsible person identified for completion those actions. The subject of audits is discussed in more detail and actioned in outcome two, ‘governance and management’.
Judgment:
Non Compliant - Moderate

**Outcome 11: Health and Social Care Needs**
Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident’s assessed needs are set out in an individual care plan, that reflect his/ her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/ her changing needs and circumstances.

**Theme:**
Effective care and support

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

**Findings:**
Overall, residents' health care needs were met through timely access to medical and allied health treatment. However, the actions associated with the previous inspection of this outcome in May 2016, had not been satisfactorily progressed and are restated in this report.

Residents were able to retain the services of their own GP (general practitioner) or opt to change to the GP services provided by a local practice. Relatives who spoke with inspectors confirmed this and stated their satisfaction with access if they had opted to change GP. In total, eight different GPs visited the centre and an out of hours GP service was also available. There was links with community mental health services who, according to the person in charge, visited the centre on a regular basis and were seen to do so on the day of inspection.

Nursing staff outlined the access to allied health services such as speech and language therapy and dietitian services. A physiotherapist was onsite two to three days per week and was responsible for assessing residents' mobility needs. However, as discussed in the health and safety outcome, potentially unsafe people moving and handling practices were seen to be implemented over the course of the inspection, therefore, it was not evident that allied health professional recommendations were implemented in practice. Monthly weights were carried out for all residents and those whose weight was of concern were weighted weekly.

The person in charge carried out pre-admission assessments prior to a resident being admitted to the centre to ensure that prospective residents' needs could be met on admission. Evidence based assessments were completed four monthly thereafter, as evidence on the centre’s electronic resident data system. Examples of matters subject to assessment included risk of falls, dependency levels, skin integrity and nutritional assessments.
As found on the previous inspection, care plans were generic and did not adequately elaborate on the care interventions required by residents, nor did they reflect the care observed in practice. As also previously identified, there was a lack of evidence of the resident and or family or next of kin involvement in the development of care plans. As identified on the previous inspection, end-of-life care plans were not in place for residents in the sample of files reviewed. End-of-life care plans were also not in place on the second to last inspection of the centre in May 2014.

Care practices were observed and staff interactions were seen to be respectful and timely. Consent was sought before carrying out a task and staff were heard to explain what they were planning to do for the resident. It was evident that staff were aware of residents' individual needs, however, as stated above, these practices were not guided by the related care plans. Residents who did not wish to engage in the care intervention, such as being assisted to eat their meal, were seen to be supported in a sensitive manner, whilst respecting the resident's wishes.

Although, overall, care practices were seen to be respectful, there was evidence of care that was task based in its approach. For example, there were occasions whereby staff were observed standing over residents while assisting them to eat their meal. Inappropriate language such as the word 'doubles' was used to discuss residents who required two staff members to assist them to carry out activities of daily living.

Nurses' narrative notes gave a basic overview of daily care, however, as previously identified, they were not linked to care plans to inform ongoing care. Statements such as 'confused as normal' were recorded to describe the resident. The sample of paper files reviewed on the day of inspection were seen to be stored appropriately without loose pages, this was an action following the previous inspection.

**Judgment:**
Non Compliant - Major

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**Outcome 18: Suitable Staffing**
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

**Theme:**
Workforce

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

**Findings:**
Non-compliances identified in the previous inspection had not been satisfactorily addressed and are restated in this outcome.

On the day of inspection there were 35 residents in the centre. Seventeen were assessed as being maximum dependency; 13 were assessed as high dependency; 4 residents were medium dependency and 1 resident was low dependency. There was one nurse rostered on duty from 07:45hrs to 20:00hrs and 20:00hrs to 08:00hrs. The person in charge stated that ideally there would be two nurses rostered to cover the day shift, however, due to annual leave and reduction in availability of other nursing staff, it had not been possible to roster two nurses on daily shifts. The person in charge stated that she covered the second nurse’s role on those occasions. Inspectors formed the judgment that the contingency plans to cover nursing hours was inadequate and required review. The person in charge stated that a new nurse was scheduled to commence in that role in early December 2016 and a senior nurse was due to take up a post in April 2017. She stated that this would resolve the nurse availability issues.

On the day of inspection there were six care assistants on duty from 07:45hrs to 14:15hrs. Four care assistants from 14:00hrs to 20:00hrs. A twilight shift commenced at 17:00hrs - 22:00hrs and two care assistants worked 20:00hrs to 08:00hrs. On Fridays and the weekends, according to the copy of rosters given to inspectors, the twilight shift was not scheduled. Instead an extra 12 hour shift was rostered on duty. Residents and relatives who spoke with inspectors said they were happy with staffing levels. The majority of staff who spoke with inspectors said that there were sufficient resources on a day-to-day basis. Some staff said that they could be under pressure from time to time. On the day of inspection, a staff member accompanied a resident to a hospital appointment, however, extra cover was not made available to cover this staff member's absence. It was observed that on that day, the second lunch sitting did not start until approximately 45 minutes behind schedule. Therefore, it was not evident, that the staffing levels available met the assessed needs of the residents at all times.

An activities coordinator was rostered Monday to Friday 09:00hrs to 17:15hrs and she was seen to engage in activities on a one-to-one basis with residents and also group activities such as sing songs. She assisted residents to attend Mass that was celebrated in the centre on the day of inspection. Feedback from resident meetings such as a request for more quizzes were seen to be incorporated in the activities schedule in the entrance foyer.

As discussed in previous outcomes, mandatory training such as fire safety, protection of vulnerable adults and safer moving and handling of people techniques was not up to date. Staff had access to additional training such as food safety, infection control and health and safety. However, only 10 staff had attended training in dementia care despite over 50 per cent of residents in the centre having a diagnosis of dementia.

A staff performance appraisal system was in place and copies of same were seen in the sample of files reviewed. However, given the examples of non-person-centred care observed by inspectors over the course of the inspection, such as staff standing when
assisting residents to eat their meal, the use of inappropriate language such as, referring to residents who required the assistance of two staff as 'doubles' and utilisation of outdated people moving and handling techniques, inspectors formed the judgment that supervision arrangements needed to be more robust.

A sample of staff files were reviewed and were found to contain the requirements of schedule 2 of the regulations. The person in charge confirmed that all staff had a current vetting disclosure in place. Up-to-date registration details were on file in the sample of relevant staff files reviewed.

**Judgment:**
Non Compliant - Moderate

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**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:**

Gemma O'Flynn  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was an audit schedule in place but inspectors found that audits did not sufficiently contribute to improvements in the quality and safety of care.

Statements in the annual review, such as mandatory training was 90% complete, were contradicted by findings on inspection.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
The resident consultation process required review, to ensure that residents were kept informed of any actions relating to their feedback or suggestions and to ensure that all feedback was captured.

1. **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:**
Resident consultation process: format of minutes reviewed to include an action plan, which will be discussed at the following meeting.
Training schedule for 2017 reviewed to ensure all necessary training is implemented
We have reviewed our auditing process to make them comprehensive

**Proposed Timescale:** 31/01/2017

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**Outcome 07: Safeguarding and Safety**

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Care plans to support residents with BPSD were not comprehensive. In the sample of files reviewed, the information in the care plans was not person centred and did not outline triggers for behaviours and associated management strategies to guide safe and consistent care.

Only 10 staff members had received training in dementia care despite despite over 50 per cent of the resident in the centre having a diagnosis of dementia.

The majority of staff had received training in the management of behaviours, four staff had not received that training. For those who had received training in the management of behaviours, some had received that training in 2010, 2011 and 2012.

2. **Action Required:**
Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

**Please state the actions you have taken or are planning to take:**
We are rolling out our training for all healthcare staff in Care Planning, Dementia Care and Behaviour that Challenges.

**Proposed Timescale:** 31/03/2017
Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff had not received up to date protection of vulnerable adults training.

3. Action Required:
Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

Please state the actions you have taken or are planning to take:
We have our home registered with the HSE to gain training in 2017 including train the trainer but until this is set up we will ensure the staff have internal training using Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures HSE Dec 2014

Proposed Timescale: 31/03/2017

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all hazards were identified, risk assessed nor did they have suitable controls implemented. For example, the smoking shelter or residents who smoked did not have specific risk assessments.

4. Action Required:
Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
Smoking risk assessments were forwarded to HIQA on 02/12/2016.

Proposed Timescale: 04/01/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Outdated and potentially unsafe moving and handling practices were observed.
5. Action Required:
Under Regulation 26(1)(b) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.

Please state the actions you have taken or are planning to take:
All staff on duty at the time of inspection have had a manual handling refresher course. We have a plan in place to ensure all staff are updated in early 2017

Proposed Timescale: 30/04/2017
Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
On the day of inspection a strong odour permeated both floors of the building.

A local infection control policy was not in place to provide centre-specific guidance to staff. For example, inspectors were given conflicting information about the frequency of specific cleaning procedures.

Kitchen staff were not wearing appropriate personal protective equipment to mitigate risk of infection to residents.

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

Please state the actions you have taken or are planning to take:
Floor has been inspected and arrangements made for repair works to be carried out.
Our local infection control policy will be reviewed.
All kitchen staff will wear appropriate PPE as per policy.

Proposed Timescale: 31/01/2017
Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
More detailed documentation was required to demonstrate that the arrangements for evacuating residents were sufficient.

It was not evident that fire drill practices comprised evacuation or simulated evacuations to ensure that arrangements for safely evacuating residents were sufficient.
Fire drill attendance records indicated that not all staff had participated in a fire drill.

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

**Please state the actions you have taken or are planning to take:**
Fire drill procedure will be enhanced to include simulated evacuations. A comprehensive plan for all staff is being implemented to ensure they are proficient in the fire drill procedure.

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**Proposed Timescale:** 31/03/2017

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
As identified on the previous inspection in May 2016 and the during an inspection in May 2015, not all staff were up to date with fire safety training.

For example, on this inspection, three staff were awaiting training, another staff member had not received training since 2012 and another since 2014.

Not all staff were able to explain the full procedure to follow in the event that the fire alarm was activated.

8. **Action Required:**
Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

**Please state the actions you have taken or are planning to take:**
All staff will be trained in fire safety, this will ensure that everyone is aware of the procedure to follow in the event of a fire.

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**Proposed Timescale:** 31/03/2017

**Outcome 09: Medication Management**

**Theme:**
Safe care and support
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were omissions in the signature field of the medication administration record, therefore, in the sample of files reviewed inspectors were unable to ascertain as to whether or not residents had received their medication as prescribed.

The person in charge did not ensure that valid authorisations for staff to administer medication were available.

There were numerous omissions in the recording of daily medication refrigerator temperatures.

9. **Action Required:**
Under Regulation 29(5) you are required to: 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.

**Please state the actions you have taken or are planning to take:**
We will complete a weekly checklist to identify any omissions in MARs and fridge temperature recording charts. These will be followed up on with each staff member. All nurses will complete a medication management course, and appraisals with staff will highlight any issues identified.

**Proposed Timescale:** 28/02/2017

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**Outcome 11: Health and Social Care Needs**

**Theme:**
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Care plans were not person centred and lacked sufficient detail to ensure consistent practice and guide care.
End-of-life care plans were not in place in the sample of files reviewed.

10. **Action Required:**
Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident’s admission to the designated centre.

**Please state the actions you have taken or are planning to take:**
All residents will have end of life care plans by 31-01-2017
Care plan training will be rolled out for all nurses early 2017
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was limited evidence that residents and or their families were involved in the review and development of care plans.

11. **Action Required:**
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident’s family.

Please state the actions you have taken or are planning to take:
We will roll out a plan to ensure each resident and or their next of kin will be spoken with, with agreement by all documented concerning the resident’s plan of care.

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Nurses’ narrative notes gave a basic overview of daily care, however, as previously identified, they were not linked to care plans to inform ongoing care.

12. **Action Required:**
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:
Nurses daily notes will link to each residents care plans. This will be discussed with nursing staff at the next staff meeting and will be emphasised during training on care planning.

Outcome 18: Suitable Staffing

**Theme:**
Workforce
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The contingency plans to cover nursing hours was inadequate and required review.

Extra cover was not made available to cover the absence of a staff member accompanying a resident to hospital. It was observed that on the day on inspection, the second lunch sitting ran approximately 45 minutes behind schedule. Therefore, it was not evident, that the staffing levels available met the assessed needs of the residents at all times.

13. Action Required:
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
We now have another staff nurse in post, which improves availability of nursing cover. Where possible, we will source extra cover to facilitate appointments.

Proposed Timescale: 04/01/2017

Theme: Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Mandatory training was not up to date as identified on this and previous inspections.

Despite over 50 per cent of residents having a diagnosis of dementia only 10 members of staff had received dementia care training.

14. 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:
All staff will receive dementia training

Proposed Timescale: 30/06/2017

Theme: Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was evidence that staff were not adequately supervised. For example:
Staff were observed to stand over residents while assisting them to eat their meals. Staff referred to residents as 'doubles' when referencing residents who required two staff to assist them. Staff were seen to utilise outdated moving and handling techniques.

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

**Please state the actions you have taken or are planning to take:**
All staff on duty have received a refresher in manual handling training. Increased nursing cover has allowed us to increase supervision of staff. Staff have been spoken to with regard to their use of poor vocabulary and mealtimes are discussed at handover each day to reinforce the etiquette of mealtimes.

**Proposed Timescale:** 04/01/2017