Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Nazareth House
Name of provider:	Sisters of Nazareth
Address of centre:	Dromahane, Mallow, Cork
Type of inspection:	Unannounced
Date of inspection:	15 September 2021
Centre ID:	OSV-0000257
Fieldwork ID:	MON-0033925

About the designated centre

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

The Sisters of Nazareth opened Nazareth House Mallow as a nursing home in 1929. The Sisters developed a new nursing home in 2018 which comprises 120 single en-suite bedrooms over 3 floors. The new development includes a new entrance, reception and lobby area, coffee dock, lounges, community hall, hair salon, conference, meeting/training rooms and physiotherapy room. The range of care needs provided by the Nursing Home are designed to meet the physical, cognitive, social, occupational, psychological and spiritual needs of residents admitted to the centre. Nursing care is provided on a long term basis or short term respite/convalescence basis to residents both male and female whose level of need and dependence may be deemed low, medium, high or maximum category. We provide 24 hour nurse-led care service, including general, respite, dementia, convalescence and palliative end of life nursing. Admissions shall normally be planned. Each prospective resident will have his/her needs assessed prior to moving into the residential care setting, a full assessment upon admission, and subsequently as required to reflect changes in need and circumstances during his/her period in residence. The Director of Nursing ensures that each resident's needs are set out in an individual care plan developed and agreed with each resident or representative. Visiting times are from 09.30hrs to 21.00hrs. However, the centre is flexible about these arrangements in particular if a resident is unwell. All visitors are expected to sign in and out of the nursing home and partake in precautionary infection control measures, as appropriate. Mass is held on a daily bases, the Church of Ireland Minister visits their members and arrangements for other denominations will be accommodated on request.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	110

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 15 September 2021	08:30hrs to 19:00hrs	Breeda Desmond	Lead
Wednesday 15 September 2021	08:30hrs to 19:00hrs	Ella Ferriter	Support

What residents told us and what inspectors observed

Overall, inspectors found that the person in charge and staff were working to improve the quality of life and promote the rights and choices of residents in the centre. The inspectors met with many residents during the inspection and spoke with eight residents in more detail. In general, residents spoken with gave positive feedback and were complimentary about the staff and the care provided in the centre.

There were 110 residents residing in Nazareth House at the time of inspection. On arrival for this unannounced inspection, inspectors were guided through the centre's infection prevention and control (IPC) procedures by a member of staff, which included a signing in process, disclosure of medical wellness or otherwise, hand hygiene, face covering, and electronic temperature check.

This was a three-storey building, with resident accommodation on the ground and first floors. The main entrance was wheelchair accessible and led into the main concourse. This was an expansive space, beautifully decorated and laid out with tables and chairs to the left, and comfortable armchair seating in the middle; there was a coffee dock to the right for residents and visitors to make tea or coffee when they visit. There were two further extensive lounges, one to the right of main reception and the second beyond the main concourse. Both were beautifully decorated and had comfortable seating for people to relax. The assembly hall, conference room and offices were located to the left of the main concourse. The hairdressers' room was located along this corridor to the right and this room was decorated in line with a salon-style room. The physiotherapy room was nearby, however, this was not in use at the time of inspection. Facilities in the basement comprised the laundry, storage facilities and the main kitchen.

Resident accommodation was set out in five units as follows: Dromore and Holy Family each with 15 bedrooms; Brittany, Hammersmith and Larmenier with 30 bedrooms each. The Holy Family unit was specifically designated to care for residents with a diagnosis of dementia. Overall, the premises was bright and clean and appeared well maintained. All units were self-contained with a dining room, day room, quiet sitting room and seating areas, sluice room, pantry, nurses' station and offices. All bedrooms were single rooms with en suite shower, toilet and wash hand basin. En suite bathroom had decorative units for residents to discretely store their toiletries; the door to these units had a mirror for residents. Bedrooms were seen to be decorated in accordance with residents' preferences. Bedrooms were adequate in size and residents had a large double and single wardrobe, comfortable chair, a desk, bedside locker with a lockable drawer. Flat-screen televisions were wall-mounted in bedrooms. Call bells were fitted in bedrooms, bathrooms and communal rooms.

Several residents said they were delighted to have their own room as it offered 'great privacy' and reported that the place was 'so clean'. Many said that they had

freedom to do what they wanted and freedom to move around in the centre. Residents were observed using the key-coded pad to independently leave their unit and go to the garden or foyer for example. One resident spoken with in their bedroom said they loved their bedroom; it had a lovely view of the countryside; and had lots of storage for their clothes and belongings. Another resident said that he loved his room, but when asked if he was he shown around and given choice of room or unit when they were re-locating to the new building, he said that he was not given choice of room or unit.

The décor in the main concourse and lounges off this was exceptional, however, the décor on the units was somewhat clinical in nature and did not provide a homely atmosphere. Nonetheless, seating areas on the units were being decorated at the time of inspection with colour co-ordinated paintwork and seating, giving a softer ambiance. A review of the lighting was requested on units as the lighting was glaring and softer lighting may enhance the atmosphere for residents.

There was an activities board by the day room on each unit with the activities of the day displayed. The September Residents' News letter was displayed in each unit and the current edition had photographs of residents' fancy dress party, information on the influenza vaccine, welcoming new staff, saying goodbye to other staff, and welcoming the new chaplin to Nazareth House. There was also reminders to residents to input their suggestions for the service. Minutes of residents' meetings were available along with other information such as inspection reports, residents' guide and statement of purpose. Minutes of residents' meetings showed that these were well attended and lots of areas were discussed relating to their quality of care and quality of life; issues were followed up in subsequent meetings. The complaints procedure was displayed on each unit and the clinical nurse manager (CNM) on each unit had responsibility at local level for oversight of complaints.

There was a beautiful church within the centre. A new priest was assigned to Nazareth House and commenced saying mass there on a daily basis. Many residents said they were delighted to have mass again on a daily basis; other reported that the church was a 'peaceful haven' which they visited during the day and sometimes twice a day. A room on the main concourse was being re-designated at the time of the inspection to become a pastoral care room. This would provide a space for residents to chat with their pastor in private if they wished.

Every Wednesday a 'coffee morning' was held in the main concourse after mass. Inspectors saw that the small tables and chairs were brought into the central area where tea, coffee and scones with cream and jam were served. Residents sat around chatting and enjoying their coffee morning; some had visitors who enjoyed the gathering as well. Music was playing in the background and some residents were singing along to the music. The atmosphere was relaxed and residents said they loved these coffee mornings. The person in charge explained that larger group activities were held in the main concourse such as the 'wine and cheese evening' in August, or in the assembly hall if there was a concert or drama being shown to residents.

Inspectors spoke with several residents in day rooms, in their bedrooms and garden

throughout the day. One resident said that staff were 'excellent', 'with excellent workmanship and professionalism'. A new resident was admitted at the time of inspection. A staff member visited the resident in their room, introduced herself, and welcomed the resident to 'Nazareth', all in a lovely friendly manner. Another resident reported that the bus trips into Mallow had commenced and she was really looking forward to going into Mallow the following day to go shopping and to the hotel for 'something to eat' as part of the trip. These bus trips were organised twice a week for residents.

There are a number of secure outdoor areas that were readily accessible to residents. One of the outdoor areas was an expansive garden with courtyards and a number of paved footpaths that facilitated residents to have long walks. Several residents were seen out in the garden from early in the morning and throughout the day. The access door to the garden was automated so residents with specialist wheelchairs accessed this area independently and with ease.

During the morning and afternoon walkabouts, most residents were up and about in the day room and garden, while a few residents remained in their bedrooms; they explained to inspectors that this was in accordance with their choice. However, observations showed that there were long periods throughout the inspection when residents were on their own in day rooms without meaningful activation.

In general, dining rooms were bright and pleasantly decorated. Mealtimes were observed and in general, these were social occasion with good interaction between residents, and residents and staff. Tables were set prior to residents coming for their meal; tables had little posies of flowers, cutlery, serviettes and condiments and looked well. Choice was offered with their main meal and desert; milk, water and juice was offered with their meal. A new specialist table was seen in Brittany which enabled five residents with specialist wheelchairs to sit together at a dining table with friends; additional tables were ordered for other units and were due for delivery. Medications were seen to be administered after dinner so that mealtime was protected for residents to enjoy their meal uninterrupted. Staff were observed to have good insight into responding to and managing communication needs and provided support in a respectful professional manner.

Kobi was the residents' gorgeous, gentle and friendly blonde labra-doodle pedigree dog. He was seen visiting residents and they enjoyed his visits and company. Staff and residents said he was a lovely addition to the life of the centre.

Visiting had resumed in line with the HSE 'COVID-19 Normalising Visiting in Long-term Residential Care Facilities' of July 2021. Visitors were observed visiting throughout the day, some took their relative for a walk in the garden, others joined residents for the coffee morning on the main concourse, and some visited in their bedrooms. Visitors were known to staff who welcomed them and actively engaged with them.

Lack of orientation signage around units to ally confusion and disorientation was highlighted on the previous inspection in July 2019. While this remained outstanding, the person in charge had samples of new orientation signage for the

dementia-friendly unit. The inspector requested this signage for all the units as part of enabling residents to independently access areas easily, such as the dining room, day room, church or main reception.

Wall-mounted hand sanitisers were available throughout the centre and staff were observed to comply with best practice hand hygiene. There were separate staff changing rooms and canteen facilities in place. Laundry was segregated at source. The laundry was examined and best practice was described by laundry staff regarding work-flows and work practices. However, hand-wash sinks were not identified as such in the laundry or sluice rooms. The inspector requested that advisory signage be erected and this was completed immediately. Some units had yellow clinical bags in white domestic waste bins or bag holders; a white bag was seen in a yellow clinical bin. This was not in keeping with infection prevention and control guidelines or safety precautions regarding segregation protocols for clinical and non clinical waste management.

Emergency evacuation plans were displayed in the centre however, primary and secondary escape routes were not differentiate to enable easy access to evacuation points. One evacuation point detailed on the map was not an actual evacuation exit; this exit was tested by the inspector and it could not facilitate an evacuation. Some of the evacuation plans displayed were not orientated to reflect their relative position in the building.

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

Capacity and capability

This was a good service with a clear governance structure with good oversight and monitoring of the service that promoted a rights-based approach to care delivery.

Nazareth House was a residential care setting operated by the Sisters of Nazareth and was registered to accommodate 120 residents. Nazareth House was part of the Sisters of Nazareth Order which operated a number of other nursing homes throughout the country. The governance structure of Nazareth House comprised the regional superior who was the nominated person representing the registered provider. The Chief Executive Officer (CEO), regional council and chief nursing officer reported into the nominated person; the person in charge reported to the CEO. The person in charge was supported on site by the assistant director of nursing (ADON), clinical nurse managers (CNMs) on each unit, accounts manager, clinical and maintenance teams. A new person in charge was appointed and due to take up post at the time of inspection. When the new person in charge took up post, there would be two ADONs supporting the governance structure.

There was evidence of good governance and oversight of the centre with monthly

clinical governance meetings, where issues such as human resources, complaints, incidents, audits, and key performance indicators were discussed and monitored. Improvements identified had associated action plans with responsibilities assigned and the progress status relating to the actions. Weekly meetings via zoom were facilitated with the chief nursing officer and the persons in charge of the other designated centres within the Nazareth group to share learning between centres. These meetings were minuted and demonstrated sharing of knowledge between centres.

The audit schedule for 2021 was evidenced and showed clinical, observational and practice audits. A very good auditing programme was evidenced with actions addressed and findings communicated for learning at unit level with monthly CNMs management meetings; agenda items included KPIs and audit results, staffing and the induction programme for new staff, complaints and infection prevention and control (IPC) updates. The audit programme enabled good oversight of the service and audit results fed into the monthly governance meetings as well as communication with families regarding interventions and care planning. QUIS observational audits were completed in areas such as the dining experience, meals served, and medication administration. Findings from these audits changed practice, for example, supervision by nursing staff at mealtimes to ensure that residents received the appropriate texture diet and fluids, and that mealtime was protected with medications administered after meals. The person in charge understood the value of auditing the service and how the results of audits and satisfaction surveys influenced quality improvement and quality of life of residents.

Clinical key performance indicators (KPIs) were maintained on a weekly basis. Information gathered included incidents of pressure ulcers, restrictive practice, falls, incidents and accidents for example. IPC data maintained comprised infection type and antibiotic treatment providing easily accessible information as part of their quality and clinical oversight.

While there was adequate care staff, there were inadequate activities staff rostered hours for the size and layout of the centre with 120 residents accommodate over two floors and five units.

The training matrix was examined and showed that staff training was up to date for manual handling and lifting, fire safety, safeguarding and infection prevention and control. However, some staff training was overdue.

A sample of staff files were reviewed. Comprehensive inductions and staff appraisals were seen in staff files. However, the registered provider had not ensured that Schedule 2 documents (documents to be held in respect of the person in charge and each member of staff) were in place for all staff prior to their commencement of employment, as part of their safeguarding arrangements.

Controlled drug records were maintained in line with professional guidelines. Other records examined included medication management and these were not comprehensively maintained.

The statement of purpose was updated on inspection to ensure compliance with the

regulations. While policies and procedures as listed in Schedule 5 of the regulations were available, the policy relating to admissions required review to ensure that it referenced current and changing Health Protection Surveillance Centre (HPSC) guidance regarding admissions to the centre. Nonetheless, the statement of purpose explicitly detailed current HPSC guidance relating to admissions and re-admissions to the centre.

The complaints' records were examined and complaints were recorded in line with regulatory requirements.

A review of contracts of care was necessary to ensure all residents had a contract of care in accordance with regulatory requirements.

In conclusion, this was a good service where a rights-based approach to care delivery was promoted.

Regulation 14: Persons in charge

The person in charge was a registered nurse, working full time in post and had the necessary experience and qualifications as required in the regulations. She actively engaged in the governance and operational management of the service. A new person in charge had been appointed and was due to take up the position at the time of inspection. The incumbent person in charge had the necessary experience and qualifications as required in the regulations.

Judgment: Compliant

Regulation 15: Staffing

The staff roster showed that the number and skill mix of care staff was appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the centre. However, the staff rostered with responsibility for meaningful activation for residents was inadequate. This was further discussed under Regulation 9 Residents' Rights.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Training relating to responsive behaviour was overdue for 34% of staff, and furthermore, administration, kitchen and laundry staff had not completed this

training even though they would come into daily contact with residents.

Judgment: Substantially compliant

Regulation 19: Directory of residents

Individual records were maintained of residents requiring long-term care and short-term care. Registers were comprehensively maintained in line with Schedule 3 requirements.

Judgment: Compliant

Regulation 21: Records

Medication administration charts were examined. Photographic identification was not available for residents who were admitted for respite care. While there was an electronically generated medication administration records (MARs), a current prescription was not part of the administration records. It was reported to the inspector that there was a prescription in the resident medical folder. While the prescription was sourced and placed with the MARS, the resident had been in the centre for several days; this meant that medications were dispensed without a valid prescription which was not in line with a high standard of nursing care and professional guidelines.

There was an easy access sheet with the dates, times and dosage of insulin given to one resident, however, the insulin was not signed for on the MARs sheet on a few occasions. Drugs given as required (PRNs) were signed for, but the time of administration was not included, consequently if someone required a further PRN dose it could not be determined if administration was within the appropriate time-lines for such a medication.

Records of administration of a controlled drug recorded in the MARS was input into blank spaces with no date of administration so it could not be determined when the controlled rug was administered.

Issues relating to Schedule 2 staff files that did not provide assurances about robust recruitment practices were:

- a full employment history was not in place in one file
- a character reference was available rather than an employment references
- one staff file did not have a reference from the employee's most recent employer.

Judgment: Not compliant

Regulation 23: Governance and management

The annual review was based on a review of the regulations rather than the national standards, with information relating to clinical key performance indicators such as falls, incidents and accidents and notifications to the Chief Inspector. There was little information relating to the quality of life of residents or that the review was undertaken in consultation with residents and their families. While a comprehensive action plan detailed improvements to the service, these all related to the regulations.

The systems in place to monitor risks required review as some areas such as clinical rooms were not securely maintained to prevent unauthorised entry which could pose a risk to residents.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

Long-stay residents had contracts of care that detailed the services to be provided, and costs plus possible additional costs that may be incurred. Residents' room numbers were not detailed in the contracts.

However, short-stay residents, for example transitional, respite or convalescence residents did not have a contract.

Judgment: Substantially compliant

Regulation 30: Volunteers

There was one volunteer to the service at the time of inspection. All appropriate documentation including vetting in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 was available. Volunteers completed an induction programme in line with best practice.

Judgment: Compliant

Regulation 31: Notification of incidents

Most notifications to the Chief Inspector were submitted in compliance with regulatory requirements, however, 6-monthly notifications were not and assurances were received that these would be submitted in the future.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints procedure was implemented in practice and complaints were maintained in line with regulatory requirements. A route-cause analysis was completed by the person in charge following each complaint and incidents were analysed to enable learning and improvement of the service. The person in charge maintained robust oversight of complaints and followed up with complainants to ensure they were happy with the outcome. Comprehensive investigations were seen to be assured that due process was followed. Appropriate notifications were submitted when warranted following feedback from residents or relatives which ensured that residents were further safeguarded.

Judgment: Compliant

Regulation 4: Written policies and procedures

The policy relating to admissions did not reference the admissions process cognisant of the current COVID-19 pandemic environment and the Interim Public Health, Infection Prevention & Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities.

Judgment: Substantially compliant

Quality and safety

Inspectors observed that, in general, care and support given to residents was respectful; staff were kind and were familiar with residents preferences and choices and facilitated these in a friendly manner.

Visiting was in line with current HPSC guidance of September 2021 and visitors were

seen throughout the day in various locations such as bedrooms, garden and day rooms. Appropriate IPC precautions were adhered with coming and going from the centre.

Residents had regular access to on-site GP consultation. There were two GPs on site during the inspection reviewing residents, discussing their care with them, proposed treatment and medical management. Residents medications were reviewed as part of consultation with their GP and ongoing monitoring and responses to medication were seen. Residents had access to specialist services such as psychiatry of old age, palliative care, speech and language, occupational therapy, geriatrician, dietitian and optician. Several residents had specialist chairs and all these had been assessed by occupational therapy.

Residents documentation showed that families were involved in care and the decision-making process. In the sample of residents' care documentation examined, appropriate records were seen regarding supports for communication needs. Pre-admission assessments were undertaken by the director of nursing to ensure that the service could provide appropriate care to the person being admitted. Care plan documentation reviewed showed mixed findings. Some care plans were person-centred with resident-specific information to guide and inform individualised care. However, some care plans were not resident-specific. Research-based assessments were seen to be in use, and while there was a 'comprehensive' assessment in place, it was very basic with very little information recorded in the narrative seen. Wound care management records seen were not maintained in line with a high standard of evidence-based nursing care. There was inconsistency between units regarding maintaining transfer records of residents when they were temporarily discharged to another service.

Laundry was segregated at source and laundry staff described best practice work-flows in the laundry to prevent cross infection in line with the national standards for infection control. Other precautions in place for infected laundry included the use of alginate bags. Sluice rooms were secure access to prevent unauthorised access to hazardous waste and clinical products, however, other clinical rooms were not appropriately secured. Issues relating to infection prevention and control and risk management were identified regarding waste management.

Fire training and simulations of compartments occurred on a routine basis to ensure staff were familiar with fire safety and could undertake an evacuation in a timely manner. Servicing of fire safety equipment was available and up-to-date. Daily fire safety checks were comprehensively maintained on Dromane unit examined. A review of emergency floor plans was required to ensure that people had access to evacuation routes relevant to the position the evacuation plans were displayed in the centre.

Regulation 11: Visits

Visiting was facilitated in line with September 2021 HPSC guidance. Measures were

taken to protect residents and staff regarding visitors to the centre with face masks, hand sanitising gels and advisory signage available throughout the centre.

Judgment: Compliant

Regulation 12: Personal possessions

Storage for personal possessions included a double and single wardrobe, chest of drawers, and bedside locker for each resident. A lockable unit formed part of the storage available to residents. Some resident had a writing desk with chair which were seen to be used for their laptop, phone charger and music centre.

Judgment: Compliant

Regulation 13: End of life

A sample of care plans were reviewed and while staff and GPs actively engaged with residents and their families regarding end-of-life care decisions, care plans were not always updated with care decisions agreed and documentation seen in medical notes. Some care plans were generic and did not provide personalised information to direct holistic individualised care in line with residents preferences and wishes.

Judgment: Substantially compliant

Regulation 17: Premises

The main concourse and lounges were of a very high standard of décor and comfort, however, corridors and walkways on and around units were clinical and in general did not convey a homely feeling. The units were very bright and softer lighting would enhance the ambiance of the units.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Meals were well presented, including textured meals. Residents were offered drinks and snacks throughout the day between meals. Mealtime was protected as medications were administered after meals to ensure residents enjoyed their dining

experience un-interrupted.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

Transfer letters when a resident required acute care or transfer to another institution so they could be appropriately cared for by the receiving facility, were not maintained on all units. Following discharge back to the centre, comprehensive information was available when the resident returned to the centre.

Judgment: Substantially compliant

Regulation 26: Risk management

A current risk management policy and safety statement were available. The risk management policy had the specified risks as listed in regulation 26.

Judgment: Compliant

Regulation 27: Infection control

Hand-wash sinks were not identified as such in sluice rooms. The inspector requested that advisory signage be erected and this was completed immediately.

Clinical waste management required review as some units had yellow clinical bags in white domestic waste bins or bag holders; a white bag was seen in a yellow clinical bin. This was not in keeping with infection prevention and control guidelines or safety precautions regarding segregation protocols of clinical and non clinical waste management.

Judgment: Substantially compliant

Regulation 28: Fire precautions

A review of emergency floor plans was required to ensure they comprehensively displayed the escape routes available. Primary and secondary escape routes were

not differentiated to enable easy identification of possible escape routes.

While emergency plans were displayed throughout the centre, they were not always orientated in line with their relative position in the premises.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

The service was in the process of upgrading their electronic documentation system to a newer electronic version. Care plan documentation reviewed showed mixed findings. Some care plans were person-centred with resident-specific information to guide and inform individualised care. However, while there was a care plan for 'infections', information included was COVID-19 related only and other potential infections were not. For example, a resident with a diagnosis of diabetes was highlighted as being of high risk of infection, but this was not included in the infection care plan. Research-based assessments were seen to be in use, and while there was a 'comprehensive' assessment, it was very basic and very little information was recorded in the narrative seen. For example, there was risk associated with mobility for one resident, but there was no information recorded to explain the risk to the individual resident, so the specific risk could not be determined.

Judgment: Substantially compliant

Regulation 6: Health care

Wound care management seen was not maintained in line with a high standard of evidence-based nursing care. For example, one resident admitted to acute care on 22 August 2021 and then returned to the centre 5 September 2021, but did not have their wound reviewed until 11th September, which was six days following return to the centre. The wound care documentation did not detail that the resident was in hospital, so it appeared that there was no wound care for the duration of their absence from the centre.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Observation and behavioural charts were in place for residents requiring additional

supports to help in identifying causes of upset or anxiety. Observation on inspection showed that staff had good insight and knew residents well and re-directed in a kind and respectful manner and provided re-assurances which allayed upset and frustration.

Judgment: Compliant

Regulation 8: Protection

Safeguarding training was provided to staff and this was up to date for all staff. Inspectors observed that residents were relaxed, well dressed and had freedom of movement.

Judgment: Compliant

Regulation 9: Residents' rights

Daily activities were facilitated between 09:30 hrs and 15:30hrs over five days per week. This meant that there were no activities scheduled after 15:30hrs each day or at the weekends. Observation on inspection showed that there were long periods when residents had no meaningful activation or supervision in day rooms.

Orientation signage around units was necessary to ally confusion and disorientation and enable all residents to independently access areas easily.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: End of life	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 25: Temporary absence or discharge of residents	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant

Regulation 9: Residents' rights	Not compliant

Compliance Plan for Nazareth House OSV-0000257

Inspection ID: MON-0033925

Date of inspection: 15/09/2021

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The staff rostered with responsibility for meaningful activities for residents has been reviewed and the centre will provide additional activities of 20 hours per week. Other options to expand the range of activities will also be explored including the recruitment of volunteers to provide activities.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Two sessions of responsive behavior training were held on the 29/09/2021 and the 12/10/2021. Clinical and non-clinical staff (administration, kitchen and laundry staff) attended the training sessions. A further training session is planned for the 26/10/21. The schedule is planned so that 100% of staff within the centre will be trained in 'Responsive Behaviours' by the end of October 2021.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: A detailed medication management audit will be undertaken on all resident's medication	

records and an action plan will be developed when necessary to address any recording issues in relation to medication management. The following areas will be included in the audit tool:
• A contemporaneous photograph of the resident is available in the Kardex for all residents who are admitted for permanent and short term care.
• a valid prescription is obtained and available as part of medication administration records
• a record of medications administered is signed by the Nurse administering the medication on the MAR (medication administration record) sheets
• the time of administration of all PRN medications are recorded in MAR sheets
• the administration of all controlled drugs is adhering to professional and regulatory guidance
It is anticipated that the audit will be fully completed by the 25/11/2021

The outcome of the inspection was discussed with the management team following the inspection and it was agreed that the internal Medication Errors policy will be implemented into practice if a medication error or poor recording practices is identified in the Medication Management Audit.

Supervision will also be provided to any staff member who requires any support to improve their medication management practices. Medication administration competency assessments will be completed for any staff member if their practice is below expected standards and this is identified in the Medication Management audit.

A robust HR audit will be completed so that Schedule 2 staff files meet the regulatory framework and best practice guidance and contain the following:
• a full employment history is available for all staff members
• an employment reference is available for all staff members; and
• each staff member has a reference from the employee's most recent employer.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Centre will come into compliance with Regulation 23 by ensuring that;
• the annual review 2021 will be developed based on the national standards, with information relating to clinical key performance indicators
• detailed information relating to the quality of life of residents undertaken in consultation with residents and their families will be included in 2021 annual review
• a comprehensive quality improvements plan related to the national standards will be incorporated in 2021 annual review
• the annual review 2021 will be completed by 25/02/2022
• there is an operational system now in place to ensure that clinical rooms are securely

maintained to prevent unauthorised entry which could pose a risk to residents.

Regulation 24: Contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
In relation to all permanent residents in the centre: all contracts of care are being reviewed to include the room numbers that is associated with the room they reside in. Residents and their next of kin are being informed of this alteration to the contract of care. The amendments to the contracts of care will be completed by 30/11/21.
Short-stay residents (transitional, respite or convalescence residents): A contract of care for short term residents will be amended to reflect the guidance and will be operational from the 25/10/2021.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
The policy relating to admissions was reviewed and amended to ensure the admissions process is cognisant of the current COVID-19 pandemic environment and the Interim Public Health, Infection Prevention & Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities.

The policy for admissions will be kept under review and updated to reflect any new guidance when issued.

Regulation 13: End of life	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: End of life:
All end-of-life care plans will be audited, and an action plan will be developed and implemented where there are any improvements identified so that the care plan meets best practice.

The audit process and action plan will ensure the following requirements:
• end of life care plans must include care decisions agreed and documented in medical notes
• end of life care plans must be person centered and contain personalised information to direct holistic individualised care in line with the residents' preferences and wishes.
• this process will be completed by 31/12/2021.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• New paint works has commenced on corridors and walkways in each of the units to convey a homelier feel;
• New wall murals and signage have been installed in the dementia specific unit
• A number of locations have been identified where it is planned to create small sitting areas with coffee table, chairs and table lamps to make the public areas homelier; and
• Re-decorating some corridors with an alternative colour scheme in order to reduce the starkness of white, make it less bright, less clinical and enhance the ambience.
The planned Completion date is the 25/02/2022

Regulation 25: Temporary absence or discharge of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents:
Transfer letters when a resident requires acute care or transfer to another institution so they will be appropriately cared for by the receiving facility, will be maintained on all units. All Nurses have been informed of this requirement.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
All hand-washing sinks in the sluice rooms are now clearly identified with advisory

signage.
The correct usage of bin liners for clinical yellow waste bins and domestic bins has been requested of all staff members. This correct usage of bin liners will be audited by the management team.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
All emergency floor plans were reviewed by the Architect on 01/10/21 in consultation with the PIC and Registered Provider onsite. The Architect agreed to make the necessary amendments to emergeny floor plans that are to be displayed to ensure;
• they comprehensively display the escape routes available
• primary and secondary escape routes will be differentiated to enable easy identification of possible escape routes (in applicable locations)
• they are always orientated in line with their relative position in the premises.
The revised floor plans will be erected and on display by the 25/10/2021

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
The centre is in the process of transitioning from the existing computerised system to a new electronic Clinical Management System. All records that existed previously are now transferred on to the new system. All care plans are being reviewed to ensure that they are person-centered with resident-specific information to guide and inform individualised care.

All Care Plans are being prioritized to ensure they meet all regulatory guidance and best practice including the following:
• comprehensive assessments
• manual handling assessments
• falls risk assessments and falls care plans
• end of life care plans
• infection control care plans
• wound documentation and care plans

This process will be completed by 15/02/2022.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Following the inspection wound care management records were reviewed by the management team to check if improvements were required. This was actioned for resident's wound care records to reflect a transfer to an acute setting or absence from the centre. The centre will ensure that wound care records are always maintained accurately. The Nurses have been made aware of this requirement.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
A review of the activity schedule has been completed and the following plan to enhance activity for residents will be implemented;
- provide 20 hours extra per week of activities
- include HCA for activities and resident supervision in day rooms
- include one additional external activity/physio session per week for residents

Additional temporary orientation signage around units, main reception, corridors and communal areas have been put in place to allay confusion and disorientation and enable all residents to independently access areas easily.

Permanent signage will be erected following feedback from the residents, families and staff on the type and style of signage preferred. This project will be completed by 28/02/2022.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(1)(a)	Where a resident is approaching the end of his or her life, the person in charge shall ensure that appropriate care and comfort, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned are provided.	Substantially Compliant	Yellow	31/12/2021
Regulation 13(1)(b)	Where a resident is approaching the end of his or her life, the person in charge shall ensure that the religious and cultural needs of the resident concerned are, in so far as is reasonably practicable, met.	Substantially Compliant	Yellow	31/12/2021
Regulation 15(1)	The registered provider shall ensure that the	Substantially Compliant	Yellow	31/12/2021

	number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/10/2021
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	25/02/2022
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	25/02/2022
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and	Substantially Compliant	Yellow	20/10/2021

	effectively monitored.			
Regulation 23(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.	Substantially Compliant	Yellow	25/02/2022
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre.	Substantially Compliant	Yellow	30/11/2021
Regulation 25(1)	When a resident is temporarily absent from a designated centre for treatment at another designated	Substantially Compliant	Yellow	31/10/2021

	centre, hospital or elsewhere, the person in charge of the designated centre from which the resident is temporarily absent shall ensure that all relevant information about the resident is provided to the receiving designated centre, hospital or place.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	20/10/2021
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	31/10/2021
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review	Substantially Compliant	Yellow	20/10/2021

	and update them in accordance with best practice.			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	15/02/2022
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Substantially Compliant	Yellow	31/12/2022
Regulation 9(1)	The registered provider shall carry on the business of the designated centre concerned so as to have regard for the sex, religious	Substantially Compliant	Yellow	31/10/2021

	persuasion, racial origin, cultural and linguistic background and ability of each resident.			
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Substantially Compliant	Yellow	30/11/2021
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	30/11/2021