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:	Nazareth Care Ireland
Address of centre:	Fahan, Lifford, Donegal
Type of inspection:	Unannounced
Date of inspection:	31 January 2023
Centre ID:	OSV-0000368
Fieldwork ID:	MON-0037583

About the designated centre

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

Nazareth House is a designated centre registered to provide 24 hour health and social care to 48 male and female residents usually over the age of 65. It provides long-term care including care to people with dementia. Residents who require short-term care or periods of respite care are also accommodated. The philosophy of care as described in the statement of purpose involves every member of the care team sharing a common aim to improve the quality of life of each resident. The centre is a single-storey building located on the main link road between Letterkenny and Buncrana and overlooks Lough Swilly. The building is attached to a convent and a church, both of which are in use. Accommodation for residents is provided in single (18) and double/twin rooms (15). 28 of the rooms had en-suite facilities. There is a range of communal areas and a safe and well-cultivated garden available for residents to use during the day.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	43

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
Tuesday 31 January 2023	09:45hrs to 17:45hrs	Nikhil Sureshkumar	Lead

What residents told us and what inspectors observed

Overall, the feedback from the residents was positive about the care they received in the centre, and some residents who spoke with the inspector commented that the staff were excellent in meeting their needs. However, the inspector found that some residents did not receive care and support in line with their needs and preferences. In addition, improvements were required to ensure that the oversight of care was effective.

The inspector met and spoke with several residents during this inspection, and most of the comments were positive. Some residents' comments were that " This is a great place to live, I enjoy watching television in the day-room, I have plenty of things to do", "the food is nice here, and the staff are good, and they give me a choice, and if I don't like something, the chef will arrange something for me".

The centre is in a single-storey building located on the main link road between Letterkenny and Buncrana and can accommodate 48 residents in a mix of twin and single bedrooms. Overall, the premises met the needs of the residents; however, the layout and size of some twin rooms did not meet the needs of all residents accommodated in these rooms. In addition, two residents told the inspector that some parts of the centre were not warm enough. One resident who was spending their day in their bedroom had their bedroom door kept open. The residents told the inspector that the room was cold and that they wanted the radiators put back on, even though the radiators were on. The inspector sought staff assistance to ensure that this resident was made warm and comfortable. A second resident who was occupying the day-room in this area was wrapped in blankets, and when the inspector enquired if they were comfortable, the resident said that they were wrapped in the blanket because the day-room was cold. This was brought to the attention of the person in charge.

This was an unannounced inspection, and on arrival, the inspector went through the infection prevention and control measures necessary before entering the centre and residents' accommodation. Following the introductory meeting with the person in charge, the inspector went for a walk around the centre.

The inspector observed that the centre has three spacious day-rooms, which includes two sitting rooms and a sunroom. The day-rooms overlook nearby Lough Swilly, and residents told the inspector that they enjoyed the views outdoors from the day-rooms. There was sufficient comfortable seating available for residents in the day-rooms, which were adjacent to each other, and the residents were observed relaxing in the day-room areas.

The inspector spent time in the day-rooms and spoke with a number of residents, and observed the activities program that was being provided in these rooms.

A monthly schedule of activities was displayed in the day-rooms of the centre;

however, this schedule was not displayed in an area that was easy for residents to access, and neither was it available in an accessible format for the residents to read, as the type font was small. As a result, the residents who spoke with the inspector were not sure about what activities were scheduled for the day. Newspapers and magazines were available in day-rooms, and some residents spent time reading the papers and watching their favourite television programs.

One activity staff was allocated to provide meaningful activities for 48 residents in the centre. The inspector observed that this was not sufficient to ensure that all residents had access to meaningful activities in line with their preferences and abilities to participate. Although the member of staff worked hard throughout the day of the inspection to engage with residents in the three sitting rooms, when this member of staff was busy providing activities for the residents in one day-room, no staff were continuously available to provide supervision and support for the residents in other day-rooms. As a result, the residents who were seated in other day-rooms were observed to spend long periods with little to do and had limited engagement with staff or each other. In addition, the inspector observed that activities were limited to those sessions provided in the day-rooms, and as a result, those residents who did not attend the day-room did not have opportunities to engage in meaningful activities. When this was brought to the attention of the person in charge, they informed the inspector that since the last inspection, they were actively recruiting for an activity person at weekends, but this was difficult to secure the right person. During the weekends, allocated staff facilitate the activities.

The inspector observed staff interaction with residents and care practices. While staff were found to be respectful towards the residents and acted promptly to attend to their care needs, the inspector observed that some staff did not follow the residents' recommended moving and handling care plans to ensure the safe moving and handling of residents. This is discussed further in the quality and safety section of this report.

The inspector viewed some residents' bedrooms, and the rooms were found to be personalised with personal items of significance, such as family photos and other memoirs. Residents had adequate storage facilities available in their bedrooms for personal items. Most residents who spoke with the inspector said that their rooms were comfortable in the centre; however, one resident who stayed in their bedroom on the day of the inspection told the inspector that they felt cold in their bedroom. The inspector noted that the temperature of the room was 17 degrees celsius and felt cold. The inspector sought out a member of staff to ensure that the resident was made comfortable. In addition, the inspector found that some twin bedrooms did not ensure residents who were using assistive equipment were able to do so without impacting on the other resident in the room. This is discussed under Regulation 17.

The residents who spoke with the inspector expressed high levels of satisfaction with the quality of food provided to them and said that they were offered plenty of choices on the daily menus. The inspector found that the menu was displayed appropriately in the dining room, and overall, the residents were able to make

choices on what they wanted to eat.

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

There was an established management team who had a comprehensive quality assurance programme in place to oversee the quality and safety of care and services provided to the residents. Post COVID-19 outbreak reviews were carried out following each outbreak, and an annual review was completed for the service covering 2022 and was available in the nursing home. However, the inspector found that overall compliance with the regulations had disimproved since the last inspection and improvements were required to ensure that the oversight of care and services was robust. This is reflected in the number of not compliant regulations that were found on this inspection.

This unannounced risk inspection was carried out to monitor compliance with the Health Act 2007 (Care and welfare of residents in Designated centre for older people) Regulation 2013 (as amended). The inspector reviewed the actions from the compliance plans of the last inspection and the information submitted by the provider and the person in charge.

The provider of the designated centre is Nazareth Care Ireland, and the provider's senior management team are involved in operating several other designated centres in Ireland. The centre benefits from access to and support from centralised departments such as human resources, information technology, staff training and finance.

Staff had access to a comprehensive training programme. This included mandatory training and updates in fire safety, safeguarding and moving and handling. Records showed that staff were up to date with their mandatory training requirements. Overall, staff who spoke with the inspector demonstrated the knowledge and skills required to carry out their roles; however, the inspector observed that some staff did not implement safe moving and handling practices in line with the centre's own policies and procedures and the training that they had received. This is addressed under Regulation 16.

The inspector reviewed the centre's roster, and the rosters showed that the number of staff allocated to provide meaningful activities was insufficient and did not meet the needs of all residents in the centre. On the day of the inspection, there was only one staff allocated to provide activities for all 48 residents in the centre. In addition, the rosters showed that no staff were rostered to provide activities for residents at weekends. This is a repeat finding from the previous inspection and had not been addressed in accordance with the provider's own compliance plan from that

inspection.

There is a clearly defined management structure in place with clear lines of authority and accountability in the centre. The provider had committed to providing 0.5 whole-time equivalent (WTE) nurse managers to carry out management and supervisory duties in their statement of purpose. However, a review of the last two weeks' rosters by the inspector showed that the nurse managers were not allocated these management hours and were working as nurses providing direct nursing care for the residents. As a result, the clinical nurse managers did not have the time that was required to carry out their management and supervisory duties.This was found to be impacting on the effectiveness of staff supervision in the designated centre and is addressed under Regulation 16.

The provider has a range of quality improvement programs in place, such as care plans audits, environmental audits, and falls audits. Management meetings and residents' meetings were held regularly in the centre, and findings from the audits were found to have been discussed in these meetings. However, the care plans audits had not been effective in identifying the issues the inspector identified on this inspection. This is further discussed under Regulation 23.

A centre-specific complaints policy was in place and available to residents and their families. Procedures were in place to ensure that all complaints were recorded and investigated and that the outcome of the investigation was communicated to the complainant. Overall, the records showed that complaints were managed in line with the centre's own policies and procedures. However, the inspector noted that the details of the investigation in relation to a recent complaint regarding a resident's food and nutritional needs had not been adequately documented, and the inspector was not assured that the complaint had been sufficiently investigated.

The inspector reviewed a range of documentation and care records in use in the designated centre. This review found that actions were required to ensure that the provider's oversight of the care records set out in Schedule 3 of the regulation was robust and that all records were maintained to the required standard. These findings are discussed under Regulation 21.

Regulation 15: Staffing

The registered provider did not ensure that the number of staff available in the centre were sufficient to meet the assessed needs of the residents. For example, the rosters reviewed by the inspector showed that there was one staff allocated to provide activities for 48 residents, which was not sufficient to ensure all residents had access to activities in line with their preferences and abilities. This was validated by the inspector's observations on the day of the inspection. Furthermore, the rosters reviewed by the inspector showed that staffing levels were not maintained at weekends even though there was no change to the number and needs of the residents accommodated in the centre. As a result, there was insufficient staff available during weekends to ensure that residents' social care needs were met and

that residents had access to meaningful activities.

The inspector reviewed a sample of residents' daily care records for the previous two weeks, which recorded that the residents who preferred to stay in their bedrooms had not participated in social care activities for several days. This was validated by feedback from residents who told the inspector they would like more opportunities for activities and entertainment. Furthermore, some staff told the inspector that the current staffing arrangement did not provide sufficient time and opportunity to provide meaningful activities for residents, especially those residents who were non-verbal and spent most of their time in their bedrooms.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff were not appropriately supervised to ensure they provided a high standard of nursing care in the centre and in line with residents' care plans. For example,

- The inspector observed two staff performing an underarm lift, which is no longer recognised as a safe moving and handling technique while transferring a resident as it poses an injury risk to the resident.
- One resident who was assessed as at risk of falls was left in the day-room in a transport wheelchair without a lap belt to prevent them from falling from the wheelchair. The resident's care records confirmed that the resident was at risk of falls and should have been transferred to a suitable chair when they reached the day-room.

Judgment: Substantially compliant

Regulation 21: Records

The registered provider had not ensured that the records set out in Schedule 3 of the Regulation were always maintained in the designated centre. For example, the daily care records of several residents that were required to be completed in a contemporaneous manner, such as fluid balance records, repositioning records, skin assessment records and pain assessment records, were not maintained in line with the centre's policy and kept up-to-date in the centre.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had failed to provide sufficient staffing resources to ensure effective oversight and delivery of care in accordance with the centre's statement of purpose (SOP). This was evidenced by

A review of the duty roster for the last two weeks and observations on the day of inspection indicated that two clinical nurse managers were also the nurses allocated to provide nursing care for residents. The clinical nurse managers were not provided with the necessary management hours in line with the centre's SOP to fulfil their roles. As a result, the provider's management systems were found to be insufficient in ensuring that the care provided to the residents was consistently and effectively monitored.

There were not enough staff on duty to ensure that residents had access to meaningful activities in line with their preferences and abilities. This is addressed under Regulation 15.

Furthermore, the provider's care plan audits failed to identify issues the inspector identified on the day of inspection. The inspector identified lapses in care records, insufficient assessments, and care planning in several residents' care files, which led to poor outcomes for the residents. This was not reflected in the provider's recent care plan audit, which showed full compliance.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider had not ensured that the nominated person to deal with the complaint had maintained all records, such as the details of the investigation in relation to a recent complaint. As a result, the inspector was not assured that this complaint had been fully investigated and any learning from the issues raised was shared with the relevant staff.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The centre's policies and procedures, as outlined in Schedule 5 of the regulations, were reviewed and updated within the previous three years.

Judgment: Compliant

Quality and safety

This inspection found that improvements were required to ensure that residents received care and support in line with their assessed needs and preferences.

Furthermore, while the premises generally met the needs of the residents, actions were required to ensure that there was adequate heating in all areas of the building. In addition, the inspector found that the configuration of some twin rooms was not suitable for residents with higher dependencies and those who required the use of an assistive device such as a hoist.

The temperatures in two bedrooms were registering 17 Celsius, and the bedrooms felt cold. In addition, the ambient temperature in one of the three day-rooms and one section of a corridor in the same area was cold. These findings were validated by residents who spoke with the inspector on the day.

The provider's fire precautions were generally found to be satisfactory. Fire drills were carried out at suitable intervals, and regular fire safety checks were carried out in the centre. The majority of the bedroom doors were found to be fitted with automatic door closure devices, which are connected to the main fire alarm system, and this system enables the fire doors to be closed in the event of a fire emergency. However, some bedroom doors were not closing properly when the door closures were released. As a result, they would not be effective in containing the fire in the event of an emergency.

The general environment of the centre was found to be clean and tidy. The provider had a comprehensive suite of infection prevention and control processes in place to manage the risk of infections in order to protect the residents. However, more focus and effort were required in relation to the cleaning of resident equipment following use. This is further discussed under Regulation 27.

There were clear processes in place to ensure that the resident's needs were assessed on admission and were reviewed regularly. Residents had care plans in place to identify the care interventions that were required to meet their needs. The inspector reviewed a sample of residents' care records and found that improvements were required to ensure that care plans were person-centred and provided up-to-date information to guide staff about the care interventions that the resident needed. Furthermore, the inspector found that the oversight of the care provided to residents on the day of the inspection did not ensure that their needs were met in a timely manner. This is discussed under Regulation 5.

Overall the inspector found that residents had access to a range of specialist health and social care services to meet their needs. However, improvements were required to ensure that residents were referred in a timely manner and that where a treatment plan was prescribed by a specialist practitioner that this was implemented in practice. This is addressed under Regulation 6.

The inspector noted that residents who stayed in their bedrooms were not supported to engage in meaningful activities on the day of the inspection. This was validated by the daily care records for these residents, which showed that they had not participated in activities in line with their assessed needs and preferences. Furthermore, staff who spoke with the inspector confirmed that activities for these residents was organised on only one day each week. This is addressed under Regulation 9.

Regulation 17: Premises

The layout of two twin-bedded rooms did not meet the needs of some of the residents accommodated in those rooms and was not suitable for residents who had high levels of mobility needs. For example:

- In one room, a resident needed to use a portable hoist for transfers in and out of bed; however, staff were not able to manoeuvre the hoist safely without encroaching on the second resident's bed space. This was confirmed with staff on the day of the inspection.
- In both bedrooms, one of the beds was located against the wall, which meant that if the resident needed two carers to provide their care, the bed would need to be pulled away from the wall, and this would encroach on the second resident's bed space.
- In each of these rooms, the wardrobe was in close proximity to the bed, which hindered access to the wardrobe for residents and staff.

These premises did not conform to the matters set out in Schedule 6 of the regulation. For example:

- Grab-rails were only installed on one side of the toilets in several shared bathrooms and toilets, and this was insufficient to support the mobility needs of more independent residents.
- A number of bedrooms had scuff marks on the walls that needed to be repaired and re-painted.
- Two bedrooms and a communal area were cold, with temperatures of 17 Celsius recorded in the bedrooms.

Judgment: Substantially compliant

Regulation 27: Infection control

The infection prevention and control processes in the centre required improvement to ensure compliance with the national standards for infection prevention and control in community health services and other national guidance. This was

evidenced by the following:

- The systems that were in place to ensure equipment was cleaned after use were not robust and did not prevent cross-contamination and cross-infection. For example, several items of resident equipment and furniture observed during the inspection were visibly unclean.
- The soft furnishings of several assistive chairs were ripped and did not support effective cleaning.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Arrangements for the containment of fire in the centre required improvement by the provider. For example, some fire doors did not close fully when released.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

The provider's arrangements to meet the assessed needs of each resident were insufficient. As a result, where residents were not receiving care in line with their care plans, this had not been identified by nursing staff or managers. This was evidenced by:

- One resident appeared to be unkempt, and the resident told the inspector that their preference was to have a shower and then have moisturising creams to be applied daily to areas of dry skin. The inspector reviewed the care files and noted that a resident's preference for a weekly shower had not been facilitated. The records showed that the resident received daily bed baths; however, there was no record that the resident had been offered a shower in line with their care plan and preferences. The inspector followed this up with the nursing and senior care staff who were caring for the resident on the day. Staff confirmed that the resident had not had a shower since they returned from the hospital because the resident had declined a shower when it was offered. However, the resident's records did not record that either a shower was offered to the resident or that the resident had refused a shower.
- The inspector observed a resident who was being cared for in bed on the day of the inspection and who appeared to be in discomfort. The resident was non-verbal and was not able to communicate the cause of their discomfort. The nurse manager who accompanied the inspector identified that the resident needed help to change their continence wear and immediately

sourced staff assistance to attend to the resident's care needs. Staff who spoke with the inspector reported that the resident had had their personal care needs attended to at breakfast time; however, the inspector met this resident at approximately 11:30, and there was no record that the resident had been checked by staff in the interim period. This was not in line with the resident's care plan, which recorded that the resident required regular staff assistance to meet their elimination needs and maintain their skin integrity.

The provider had not ensured that the residents' care plans were appropriately reviewed in the centre to ensure their current care needs were accurately reflected in care plans. For example:

- The inspector reviewed the wound assessment records of a resident with a pressure ulcer and found that the resident's wound assessments were not carried out following readmission from a hospital. The records indicated that the wounds were assessed after 11 days of readmission from the hospital, and the wound had deteriorated when assessments were carried out. The resident's records indicated that care plans were not reviewed, and appropriate and timely referrals were not made following a deterioration of the wound. On the day of inspection, the staff confirmed to the inspector that the wound had further deteriorated and that the resident was prescribed an antibiotic to treat the wound infection. As a result, the inspector was not assured that timely actions were taken to support this resident's needs in the centre.
- The inspector reviewed the skin integrity assessment of one resident and found that it had not been sufficiently carried out to reflect the current needs of this resident. As a result, this resident's skin integrity care plan had not been sufficiently developed to direct staff to take appropriate measures to prevent pressure ulcers from developing.
- The provider had not made the necessary arrangements to ensure that the residents who were on medications to manage pain and mood disorders were reviewed for the effectiveness of the interventions. For example, pain assessments and mood assessments were not carried out at regular intervals as described in the residents' care plans to review the effectiveness of their treatment.
- While fluid monitoring records were maintained for three residents, the nursing records reviewed by the inspector did not indicate that the residents' care plans were reviewed and sufficient interventions were taken when residents' fluid intake levels became significantly low and did not meet the fluid requirements set out in their care plans.

Judgment: Not compliant

Regulation 6: Health care

The registered provider had not made adequate arrangements to ensure that the

residents were provided with appropriate medical and health care, including a high standard of evidence-based nursing care in accordance with professional guidelines. For example:

- A resident with deterioration of a pressure ulcer did not have a timely referral to their GP to ensure that they received the necessary support to meet their care needs. Furthermore, when changes in wound grades were noted, residents were not referred to a dietitian and were not re-referred to a specialist wound care nurse to seek advice regarding the most appropriate plan of care.
- One resident with noted deterioration in mobility was not referred to a physiotherapist to ensure they received the most appropriate care.
- One resident with difficulty in handling cutlery at meal times was not referred to an appropriate health care service to ensure that they received the most appropriate care. Furthermore, even though staff were available to support this resident during meal time, they were found to be helping other residents simultaneously, and the assistance provided to this resident was insufficient.
- One resident who had been assessed by a physiotherapy service in 2022 and had been prescribed a physiotherapy plan for daily movement and exercise did not have a care plan in place for the recommended treatment. Although staff who spoke with the inspector had been informed about the exercise programs recommended by the physiotherapist, this prescribed treatment was not set out in a care plan for them to follow. Furthermore, when the inspector reviewed the daily care records for the resident, they found that there was no record that the recommended treatment plan had been provided for the resident. Staff who spoke with the inspector confirmed that the resident had not received their recommended treatment but could not offer an explanation as to why this was.

Judgment: Not compliant

Regulation 8: Protection

Measures in place included facilitating all staff to attend safeguarding training. Staff were knowledgeable regarding safeguarding residents and were aware of their responsibility to report any allegations, disclosures or suspicions of abuse. Staff were familiar with the reporting structures in place.

Judgment: Compliant

Regulation 9: Residents' rights

The provider had not ensured that all residents were provided with sufficient

opportunities to participate in meaningful activities in line with their preferences and capacity. For example:

- The inspector found that several residents in a day-room were found to have offered dolls as part of doll therapy when activity staff spent time with residents in the other day-rooms; however, not all residents appeared to have shown interest in this activity.
- The inspector observed that staff-resident interactions were limited to care interventions, such as personal care and meal times, for two residents who spent most of their day in their bedrooms.
- One resident was observed not participating in the group activities that were provided on the day of the inspection. The resident was not offered any alternative activities even though the resident's care plan required them to have one-to-one support, such as assisted newspaper reading daily. This resident's daily care records showed that they had not had access to meaningful activities in line with their care plan for the previous three weeks.

Televisions were not available in a number of the twin bedrooms. There was no clear reason why these rooms did not have televisions when others did. Furthermore, one of the residents accommodated in one of these rooms told the inspector that they needed a television in their room. This was brought to the attention of the person in charge on the day.

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 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Nazareth House OSV-0000368

Inspection ID: MON-0037583

Date of inspection: 31/01/2023

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The Registered Provider will come into compliance with Regulation 15 by; • By ensuring that that the number of staff available in the centre is sufficient to meet the assessed needs of the residents. • Ensuring that the centre has staff who are trained to deliver activities each week day and at weekends. • Additional staff will be made available to provide activities and a recruitment process is currently ongoing to appoint an additional activity support person. • Additional training courses have been organized for staff involved in the provision of activities. • Ensuring that the staffing levels will deliver safe and effective care for all residents and meet all their individual needs. • The staff schedule will be continually be reviewed to ensure there will be staff available at the weekends to facilitate residents' social activities and lifestyle preferences.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The Registered Provider will come into compliance with Regulation 16: • By monitoring staff performance and their actions to ensure that they perform their duties as trained. • Staff are provided with moving and handling refresher training every 3 years. The current staff team have all received moving and handling training. Where an employee is observed to require refresher training before it is due, this training will be prioritized and	

organized.
• The current systems will for continue for Staff to be provided with up-to-date training and access to supervision and education to meet the needs of residents with physical and cognitive impairment.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
The Registered Provider will maintain compliance with Regulation 21 by;
• Ensuring that all records that are required are maintained.
• Ensuring that all staff enter contemporaneous entries about care delivered into the new tablets that have been developed and introduced in the centre. These user friendly tablets enable staff to complete documentation at the point of 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. These care plans are drawn up with the involvement of the resident, their relative as appropriate and reflect his/her changing needs and circumstances.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Registered Provider will maintain compliance with Regulation 23 by;
• Continuing with the existing governance and management systems in place.
• By ensuring the centre has a Clinical Nurse Manager that has supernumery hours as deemed necessary to meet the leadership and management functions within the centre.
• By introducing any other systems which improve the existing governance and management arrangements.
• The designated center will uphold the principle that good leadership, governance and management, in keeping with the size and complexity of the service provided, are fundamental starting points for sustainably delivering safe, effective person-centred care and support.
• A key function of effective governance is specifying the accountability and reporting structures in the service and these are clearly identified within the designated center.
• The designated center has clear accountability arrangements in place to achieve the delivery of high quality, safe and reliable healthcare.
• The designated center has formalized governance arrangements for assuring the delivery of high-quality, safe and reliable healthcare.

• The designated center maintains a publicly available statement of purpose that accurately describes the service provided, including how and where they are provided. • The designated center set clear objectives and has developed a clear plan for delivering high-quality, safe and reliable healthcare services. • The designated center has effective management arrangements to support and promote the delivery of high-quality, safe and reliable healthcare services.

Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: The Registered Provider will maintain compliance with Regulation 34 by; • The continued implementation of existing policies and procedures for the management of feedback; • The review of previous complaints and how they are managed to identify if the process can be improved and share any lessons learned; • The complaints procedure has been continually updated to reflect best practice and includes a new updates on governance, the oversight of complaints, redress; and • The review of complaints is completed weekly during the governance and management meeting. The agenda and minutes for these meetings are available for inspection.	

Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The Registered Provider will maintain compliance with Regulation 17 by; • Ensuring that the premises are fit for purpose and are maintained to a high standard. • The location, design and layout of the centre are suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. • There is an ongoing maintenance plan in place which includes upgrading bedroom interiors, installing grab rails where required and equipment maintenance etc. A full time maintenance person is employed in the centre. • The bed space in each room has been reviewed and where staff need to assist a resident requiring a portable hoist for transfers in and out of bed, adequate space has been created. • The height of communal toilets is assessed as meeting required standards and are suitable for residents with mobility needs. Suitable adaptation equipment will be made available for any resident who requires a height adjustment. • Any bedrooms with scuff marks on the walls are included in the ongoing maintenance programme to be re-painted. The centre has a full time maintenance man employed who	

is a painter by profession.	
Regulation 27: Infection control	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the actions will result in compliance with the regulations. The Registered Provider will maintain compliance with Regulation 27 by; • Continuing to implement the existing good IPC policies and procedures. • The centre has implemented and embedded systems and assurance processes to monitor infection prevention and control which includes auditing, training and continued supervision of staff.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: The Registered Provider will maintain compliance with Regulation 28 by; • Continuing to carry out maintenance programmes to ensure that all aspects of the building meets the necessary requirements for Fire Safety. • Any fire doors observed to be not closing correctly when released will be adjusted within the routine maintenance programme. • When assessing fire doors the correct procedure has to be used- for example some doors are closed by noise activation. • An Annual Fire risk assessment is completed and was available for inspection; • Fire training and fire drill are undertaken at regular intervals. Appropriate arrangements are in place to service the firefighting equipment and alert smoke/ fire detection.	
Regulation 5: Individual assessment and care plan	Not Compliant
Outline how you are going to come into compliance with Regulation 5: Individual	

assessment and care plan:
The Registered Provider will come into compliance with Regulation 5: Individual assessment by;
• Conducting a review of all care plans and assessments in place to ensure they are person centred and direct the implementation of the correct interventions and support required for the resident in agreement and consultation with the resident;
• Continue to audit all care plans to identify any gaps in required information that directs the delivery of safe and effective care;
• Continue to audit care records to ensure that there are no gaps for interventions that take place including records for the showering of residents,
• Ensure staff records when a resident refuses the offer of a shower or a bath from staff members;
• The Registered Provider has put in place systems to ensure best practice for wound management including a weekly wound care reporting audit;
• Ensuring all mood and pain assessments are completed as required for those residents who require that type of assessment;
• Maintain a robust supervision process for staff members who are involved in the development of care plans and assessments; and
• The provision of additional education and training to any staff member when this is identified as being necessary.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• The Registered Provider will maintain compliance with Regulation 6 by;
• Making adequate arrangements to ensure that the residents are provided with appropriate medical and health care, including a high standard of evidence-based nursing care in accordance with professional guidelines.
• Ensuring the appropriate referral is made when this deemed nescessary to other professionals and keeping a record of this referral for inspection;
• Ensuring that any interventions by community professionals are recorded in the progress notes and amendments are made to care plans when directed by community professionals;
• Ensuring the wellbeing and welfare of each resident is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health and social care.
• Ensuring weekly 'Quality Improvement' audits are completed and is monitored by the PIC. Hard copy records were available for inspection.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: The Registered Provider will maintain compliance with Regulation 9 by; • Upholding the Human Rights of all residents including the right to make decisions are respected. • Ensuring a resident's decision not to participate in a group activity is respected; • When a resident refuse to take part in an activity staff will attempt to provide an alternative activity; • TV's are always provided to residents who wish to have them. If a resident refuse to have a TV then this decision is respected; • Residents are facilitated to exercise their civil, political, religious rights and are enabled to make informed decisions about the management of their care through the provision of appropriate information. Residents guides have been issued to all residents and these guides support residents achieving this outcome. Each resident is facilitated to communicate and is enabled to exercise choice and to maximise their independence. • Each resident is facilitated with opportunities to participate in meaningful activities, appropriate to his/her interest and preferences. • The use of doll therapy in dementia care appears to be increasing, even though there is limited empirical evidence to support its use and therapeutic effectiveness. It is suggested by advocates of doll therapy that its use can alleviate distress and promote comfort in some people with dementia. Despite these encouraging claims, the theoretical basis for the use of doll therapy in dementia is poorly understood. The staff will offer alternative activities to a resident who may not take part in doll therapy.	

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 15(1)	The registered provider shall ensure that the 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.	Not Compliant	Orange	30/09/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/06/2023
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared	Substantially Compliant	Yellow	30/09/2023

	under Regulation 3.			
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	30/11/2023
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.	Substantially Compliant	Yellow	30/06/2023
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	30/09/2023
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/06/2023
Regulation 27	The registered	Substantially	Yellow	30/09/2023

	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.	Compliant		
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	30/06/2023
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	30/05/2023
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs	Substantially Compliant	Yellow	30/06/2023

	of each resident when these have been assessed in accordance with paragraph (2).			
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.	Not Compliant	Orange	30/06/2023
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.	Not Compliant	Orange	30/06/2023
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in	Not Compliant	Orange	30/06/2023

	activities in accordance with their interests and capacities.			
Regulation 9(3)(c)(ii)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may communicate freely and in particular have access to radio, television, newspapers and other media.	Substantially Compliant	Yellow	30/05/2023