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:	Dromahane, Mallow, Cork
Type of inspection:	Unannounced
Date of inspection:	11 July 2023
Centre ID:	OSV-0000257
Fieldwork ID:	MON-0040844

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; it is a three storey building with resident accommodation on the ground and first floor. Bedrooms comprise 120 single en-suite bedrooms. The new development includes a new entrance, reception and lobby area, coffee dock, lounges, community hall, hair salon, conference, meeting/training rooms and social club. 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. The centre provides 24 hour nurse-led care service, including general, respite, dementia, convalescence and palliative end of life nursing.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	105

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 11 July 2023	09:20hrs to 18:00hrs	Breeda Desmond	Lead
Wednesday 12 July 2023	09:00hrs to 17:00hrs	Breeda Desmond	Lead
Tuesday 11 July 2023	09:20hrs to 18:00hrs	Ella Ferriter	Support
Wednesday 12 July 2023	09:00hrs to 17:00hrs	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 atmosphere was relaxed and care was delivered in a calm and un-rushed approach. The inspectors met with many residents during the inspection in day rooms, dining rooms, in their bedrooms and gardens, and spoke with 20 residents and five visitors in more detail. Residents spoken with gave positive feedback and were complimentary about the staff and the care provided in the centre; the cleanliness of the centre and the variety of activities. One resident said 'it was the best place on earth', another said that 'everything as excellent' and 'better than a hotel'. Visitors were equally as complimentary, explaining that the staff were very good to keep them up to date regarding their relative's condition; and were always made welcome when they visited.

There were 105 residents residing in Nazareth House at the time of inspection. On arrival for this unannounced inspection, inspectors were guided through the centre's risk management procedure by a member of staff which included hand hygiene, and signing-in process. An opening meeting was held with the person in charge and assistant person in charge (ADON) which was followed by a walk-about the centre with the person in charge. It was clear that the person in charge knew all the residents well and their care needs along with supports necessary to enable residents to have a good quality of life.

Nazareth House was set on a large landscaped site, located in close proximity to the village of Dromahane. It 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, and comfortable armchair seating in the middle; there was a coffee dock for residents and visitors to make tea or coffee when they visit. Coffee mornings were facilitated here. 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 corridor leading to the right was redecorated since the last inspection with shop-like frontage of 'An Post', a shop, hairdressers' salon and social club. The hairdressers' room was a salon-style room with ample space for residents to sit and chat while waiting to have their hair up-styled. The shop opened in the mornings and the running of the shop was facilitated by volunteers. The social club was re-furbished since the last inspection; this was an expansive room with seating areas, an large smart television, and a 'magic table' for sensory interaction therapy for residents. Facilities in the basement comprised the laundry, storage facilities, the main kitchen and maintenance.

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. All units were self-contained with a dining room, day room, quiet sitting room and seating areas, sluice room, household cleaners' room, pantry, nurses' station and offices. Bedroom doors had residents names and some had pictures of photographs displayed. All bedrooms were single rooms with en suite shower, toilet and wash hand basin. En suite bathrooms 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, communal rooms and gardens. Several residents spoken with in their bedrooms said they loved their bedroom with lovely view of the countryside; and had lots of storage for their clothes and belongings. The lighting on units was changed to a softer lighting to enhance the atmosphere for residents.

While there were quiet day rooms on each unit, they had not reverted back to residents' use following the lifting of COVID restrictions as staff lunches were in the fridge and staff bags were stored on the shelving units. This was addressed on inspection whereby staff removed their belongings from these rooms to the staff dining facilities provided.

There was an activities board by the day room on each unit with the activities displayed. Additional posters showed activities such as the knitting club, gardening club, gentlemans' club, exercise with Kieran, and the crafty corner. Day trips were frequently organised including a weekly shopping trip to the local town of Mallow. The monthly residents' news letter was displayed as well as minutes of residents' meetings, inspection reports, residents' guide and statement of purpose.

There was a beautiful church within the centre and mass was held there on most days. Many residents said they were delighted to have mass on a daily basis; others reported that they moved residential care because daily mass was said there.

Every Wednesday a 'coffee morning' was held in the main concourse after mass and the priest joined the residents for a chat. Inspectors saw that tables and chairs were brought into the central area where tea, coffee, muffins, and Danish pastries were served. Residents sat around chatting and enjoying their coffee morning; some had visitors who enjoyed the gathering as well. The atmosphere was relaxed and residents said they loved these coffee mornings. Staff knew residents preferences of beverage and encouraged residents to part-take in the delicacies offered. The person in charge explained that larger group activities were held in the main concourse such as the 'wine and cheese evening', or in the assembly hall if there was a play or concert.

Residents were observed using the key-coded pad to independently leave their unit and go to the garden or foyer for example. Residents in the dementia specific unit,

Holy Family, had access to an enclosed garden with walkways and seating. One resident showed the apple trees and explained they were monitoring the apples and would pick them some day. There was an expansive enclosed garden with courtyards and a number of paved footpaths that facilitated residents to have long walks. Raised flower beds were located around the garden and were part of the gardening club activities. 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 in accordance with their preference or assessed needs. An array of activities were observed throughout both days of inspection. Group activities comprised exercise programmes, sing-songs, morning coffee in the coffee doc following mass; one-to-one sessions included hand massage, reading the news paper and chatting with residents. Kobi was the residents' gorgeous, gentle and friendly labra-doodle pedigree dog. He was seen visiting residents and they enjoyed his visits and company. Staff, residents and visitors said he was a lovely addition to the life of the centre.

Residents had their breakfast in bed or in their bedroom. During the morning walk-about at 9am, dining tables were set for lunch/dinner time. 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. Good choice was offered to residents for all their meals. Meals were well presented, including textured meals and residents gave positive feedback about the quality of food served. Specialist tables were in place which enabled five residents with specialist wheelchairs to sit together at a dining table. Medications were seen to be administered after dinner so that mealtime was protected for residents to enjoy their meal uninterrupted. The main meal of the day was served at 12mid-day and residents said they felt this was too early; residents reported that some days it commenced at 11:50am.

A morning medication round was observed and the nurse actively engaged with residents, chatting and providing the resident with updates on the local news as well as medications being administered. This was done in a relaxed and social manner. Residents receiving personal care were assisted in a calm and relaxed manner and staff actively engaged with residents. Most staff were observed to have good insight into responding to and managing communication needs and provided support in a respectful professional manner.

Visiting had resumed in line with the HSE 'COVID-19 Normalising Visiting in Long-term Residential Care Facilities' of July 2023. 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.

New orientation signage was displayed around units to ally confusion and disorientation and enable 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. Laundry was segregated at source. The laundry staff described best practice regarding work-flows and work practices to prevent cross infection in line with the national standards for infection control. A regime was described to ensure curtains including net curtains were laundered twice a year. Laundry staff explained that relevant residents had two hoist slings so that one could be laundered on a weekly basis. 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. Obsolete chemical dispensers in housekeeping rooms were removed at the time of inspection and handwash soap dispensers re-located to the handwash sinks along with the associated hand-washing advisory signage.

The centre was visibly clean and resident and visitors commented on the cleanliness of the centre. One of the cleaners spoken with explained the regime and colour-coded clothes used for cleaning bedrooms, bathrooms and communal areas.

There was an external holding area to the side of the building for maintaining domestic and clinical waste. Four of the six large clinical waste bins were secured and the other two had broken locks. These were discarded at the time of inspection to ensure the safe storage of clinical waste was maintained in secure containers.

Some fire door closures were ineffective and the maintenance person reviewed these and addressed the issues identified immediately. Evacuation plans displayed were orientated to reflect their relative position in the building. The main fire panel was located at reception with local fire panels on each unit. While there was fire safety instructions alongside the panels, escape routes with compartments were not displayed to enable orientation and instant access to fire location. Emergency evacuation plans with compartment identification were immediately displayed with the associated legend detailing compartments.

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 of the service that promoted a rights-based approach to care delivery.

Nazareth House was a residential care setting operated by Nazareth Care Ireland 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 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 two assistant directors of nursing (ADON), clinical nurse managers (CNMs) on each unit, accounts manager, administration, clinical and maintenance teams.

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 CEO and the persons in charge of the other designated centres within the Nazareth group to share learning between centres.

The record management system was excellently maintained. While some audits were completed, the range of audits was limited and the array of questions within the audits did not ensure a comprehensive evaluation, such as the medication audit did not include aspects of controlled drug management, or the food and nutrition audit did not review the times of meals being served for example. Of the audits completed, comprehensive action plans were developed to address issues; this included time-lines for update and completion with responsibilities assigned to ensure the actions were addressed. Clinical key performance indicators (KPIs) were maintained on a weekly basis. Information gathered included incidents of pressure ulcers, restrictive practice, complaints, falls, incidents and accidents for example.

A review of staff levels was required as there was a deficit of twilight care hours to ensure appropriate medication rounds, personal care delivery and supervision. The training matrix was examined and showed that staff training was up to date for mandatory training of manual handling and lifting, safeguarding and infection prevention and control. A sample of staff files were reviewed. Comprehensive inductions and staff appraisals were seen in staff files. 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.

Policies and procedures as listed in Schedule 5 of the regulations were available. The contracts of care were updated on inspection to ensure compliance in accordance with regulatory requirements. The insurance certificate was updated on inspection to reflect the current registered provider. While notifications were submitted regarding incidents, some were not submitted within the appropriate time-lines as required within the legislation.

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. He actively engaged in the governance and operational management of the service.

Judgment: Compliant

Regulation 15: Staffing

A review of this staffing level was requested to ensure supervision, medication rounds and appropriate care could be facilitated:

- Holy Family and Dromore was a 30 bedded unit divided into two individual units with the Holy Family as a secure 15 bedded dementia-specific unit. They were staffed the same as the other units even though they operated independently due to the secure nature of Holy Family. While this did not appear to be an issue during the day time, it was a concern during twilight hours as there was one nurse and two HCAs for 30 residents (15 residents in Dromore and 15 residents in the secure Holy Family unit) and many residents were high to maximum dependency requiring two staff to provide care. Following hand-over report at 8pm, the nurse undertook the medication round on one unit while the HCAs provided care on the other unit. This resulted in no supervision of day rooms on both units, and appropriate care and supervision could not be guaranteed.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Records showed that there was good oversight of staff training needs; training was scheduled for the weeks following the inspection for topics such as manual handling and lifting, cardio-pulmonary resuscitation and safeguarding to ensure all training remained in date for staff.

Judgment: 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 22: Insurance

The insurance certificate was updated on inspection to reflect the change in management from The Sisters of Nazareth to Nazareth Care Ireland. Insurance certificate included injury to residents and other risks such as loss or damage to property.

Judgment: Compliant

Regulation 23: Governance and management

A more robust system was required to ensure the service was effectively monitored as:

- the range of audits completed was limited; while there was a schedule of audit folder for 2023 with some audits completed, a lot of the information included in the folder comprised key performance indicators rather than audits
- the array of questions within the audits did not always ensure a comprehensive evaluation, such as the medication audit did not include aspects of controlled drug management, or the food and nutrition audit did not review the times of meals being served for example
- twilight hours staffing levels on Dromore and Holy Family did not ensure effective supervision, safe medication practice or appropriate delivery of care
- fire safety relating to simulated evacuations of compartments had not been undertaken outside of training to be assured of fire safety precautions.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

Residents had contracts of care that detailed the services to be provided, and fees to be charged. While the contract stated that additional costs would be incurred they did not detail what these costs entailed. This was updated on inspection with

the additional cost incurred relating to the activities programme provided.

Judgment: Compliant

Regulation 30: Volunteers

There were three volunteers to the service. Their files were updated on inspection to include their roles and responsibilities in line with regulatory requirements. Vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012, were in place for volunteers. Observation on inspection showed that volunteers were appropriately supervised.

Judgment: Compliant

Regulation 31: Notification of incidents

While notifications were submitted in accordance with incidents in the centre, some were not submitted within the required time frame specified in the regulations; one notification was 10 days overdue, another three days overdue, for example.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The policy relating to medication management was updated on inspection to include the policy guidance on handling and disposal of unused or out-of-date medicines to ensure compliance with Schedule 5 of the regulations.

Judgment: 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. Staff actively engaged with residents and feedback from residents was positive about the care they received.

Visiting was in line with current HPSC guidance of July 2023 and visitors were seen throughout the day in various locations such as bedrooms, garden and day rooms.

The expertise of the HSE liaison person for residents under 65yrs old was facilitated and welcomed and she acted as advocate for these residents to access services and specialised equipment. Advocacy was available to all other residents via the national advocacy service; the person in charge ensured that all residents were given the new patient advocacy leaflets and discussed this as part of the residents' meeting. The local advocate was on site every other week to chat with residents and provide information and support.

Residents documentation showed that families were involved in care and the decision-making process. Pre-admission assessments were undertaken by the person in charge to ensure that the service could provide appropriate care to the person being admitted. Day and night duty care updates were written as part of residents' daily narrative. Care plan documentation reviewed showed mixed findings and inconsistency between units regarding assessments, care planning and the temporary transfer of residents to another care facility or discharge information. Some care plans were person-centred with resident-specific information to guide and inform individualised care, however, some were not and required attention to ensure assessment and medical histories informed comprehensive care planning to deliver individualised care.

While there was little information in some care records regarding residents' menu preferences, the records maintained by kitchen staff showed detailed information regarding residents' preferences for breakfast, dinner and supper.

Current records of servicing of equipment such as the fire hydrant and pump house were available. Servicing records of other fire safety equipment such as extinguishers and emergency lighting were available and up-to-date. Daily and weekly fire safety checks were comprehensively maintained. Fire drill reports were part of fire safety training, and while simulations formed part of this training, this required further action to be assured that evacuations could be completed in a timely manner.

Regulation 11: Visits

Visitors gave positive feedback about all aspects of life in the centre. Visitors were seen in the centre from early morning onwards. Staff actively engaged with family members and gave updates on their relatives' condition. Visitors sat with their relatives in day rooms, residents' bedrooms or walking in the garden enjoying the sunshine and fresh air.

Judgment: Compliant

Regulation 12: Personal possessions

Residents had good access to personal storage space in their bedrooms of double wardrobes, chest of drawers and bedside locker. Some residents had additional furniture in accordance with their preference and choice.

The laundry on site cared for residents' personal clothing and good systems were described by laundry staff to ensure labelling of clothes to enable clothing to be returned in a timely manner.

Judgment: Compliant

Regulation 13: End of life

A sample of end-of-life care plans were reviewed which demonstrated that the GP and staff actively engaged with residents and their families regarding end-of-life care decisions; care plans provided personalised information to direct holistic individualised care in line with residents preferences and wishes.

Judgment: Compliant

Regulation 17: Premises

The main concourse and lounges were of a very high standard of décor and comfort. Following from the findings of the last inspection, corridors and walkways on and around units were refurbished to create a more welcoming and homely feeling. The hallway leading to the units downstairs had murals of shop-frontages painted such as 'An Post', a hair-dresser's salon and shop. The shop was open in the mornings for residents to do their own shopping for toiletries and treats. Softer lighting was installed in each unit creating a more calm environment. Seating areas in each unit were created with feature walls, armchairs and coffee tables for residents to sit and relax.

The social club room was upgraded with an expansive smart TV which enabled residents access a full range of programmes on line. New leather couches enabled residents to relax and enjoy programmes. The 'magic' table was a new addition whereby sensory and interactive images were displayed as part of sensory engagement with residents with a diagnosis of dementia.

Residents had access to an expansive enclosed garden with walk-ways, seating areas and raised flower beds; the smoking shelter was located near to the entrance to the garden. There was an enclosed garden as part of the dementia-specific unit

and residents were seen to enjoy this space.

Judgment: Compliant

Regulation 18: Food and nutrition

Action was required to enable residents have choice regarding their dining:

- during the morning walk-about at 9am, dining tables were set for lunch/dinner time, so the choice of having breakfast in the dining room was not afforded to residents
- the main meal of the day was served at 12mid-day and some days it commenced at 11:50am, and residents said they felt this was too early. This was not in keeping with a reasonable time of being served ones' main meal.

Judgment: Substantially compliant

Regulation 20: Information for residents

The residents' guide was updated on inspection to include the terms and conditions relating to residence in the centre, that is, their contract of care.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

Action was required to ensure appropriate records were maintained as follows:

- while transfer letters were maintained on site of occasions when a resident required acute care or transfer to another institution so they could be appropriately cared for by the receiving facility, the most recent transfer letter had little information to ensure the resident could be cared for in accordance with their assessed needs
- one discharge letter of a short-stay resident to the public health nurse did not provide sufficient information to direct public health to appropriately manage care of the resident following discharge back to the community.

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 28: Fire precautions

Action was required regarding fire safety as follows:

- there was no evidence of regular simulations of evacuations of compartments in the centre particularly as some compartments were large containing up to 10 and 13 residents. This did not provide assurance that compartments could be evacuated in a timely manner with minimal staffing levels,
- 14 staff were outstanding fire safety refresher training
- personal emergency evacuation plans were reviewed on one unit, and all residents, irrespective of their dependency, were documented as requiring wheelchair evacuation for day time and bed evacuation at night time. This required review to ensure assessments were accurate for each individual and that the appropriate support was in place in the event of an emergency evacuation.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

There were mixed findings in relation to assessment and care planning. Action was necessary on some units to ensure residents' assessment and care planning was individualised to support person-centred care, and that care documentation was formally evaluated to ensure the assessment and care plan in place was effective, as follows:

- some assessments were not comprehensively completed or had no information to inform the care planning process to enable individualised care delivery
- occasionally, residents' medical history did not inform assessment or care planning to enable the resident to be cared for in accordance with their medical needs
- wound care was not assessed appropriately or care planning implemented to enable best outcomes for residents. Some wounds care plans had not been discontinued when the wound healed; another resident with a pressure ulcer

did not have a care plan to inform their care
- one resident on daily schedule 2 pain medication did not have a pain management care plan to enable assessment of the effectiveness of pain medication
- when 'as required' PRN medication was administered the reason for the medication administration was not detailed to enable staff monitor a resident's pain and the effectiveness of the medication for example
- while safeguarding plans were developed the safeguarding care plan did not reference the actions to be taken regarding known safeguarding concerns
- social support activity plans indicated that the resident was involved in an activity, but did not detail the activity to enable follow up and inform the ongoing individualised activity programme
- behavioural support plans were not comprehensively completed as many of the assessment did not detail the resident's underlying emotional state, and some stated that the resident's emotional state was not applicable.

Judgment: Not compliant

Regulation 6: Health care

The GP was on site five days per week. Residents medications were reviewed as part of consultation with the GP and ongoing monitoring and responses to medication were seen. Residents had access to specialist services such as psychiatry of old age, palliative care and associated support services, speech and language, occupational therapy, geriatrician, dietitian and optician. Several residents had specialist chairs and all these had been assessed by occupational therapy. The physiotherapist was on site on a weekly basis, usually on Fridays, to support residents with their mobility, post falls assessment and care planning as part of the falls prevention programme.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

A restraint-free environment was promoted. There was very little environmental restrictive practice in place and restraint was seen to be used in line with national policy. A restrictive practice register was maintained and good oversight was maintained at unit and management level to ensure adherence with national policy.

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.

Robust systems were demonstrated regarding protection of residents' monies; there was a separate resident property account with appropriate records, signatures and invoices per transaction.

Judgment: Compliant

Regulation 9: Residents' rights

Additional activities staff were recruited since the last inspection. There was a daily schedule of activities displayed on each unit, and this included the person facilitating the activity and the location, as often when there were large numbers attending activities, the activity could be held in the social club room or the coffee doc in reception.

Monthly residents meetings were facilitated by the person in charge. Minutes showed that there were lots of items discussed and residents gave substantial feedback on the life and running of the centre. Minutes of residents' meetings showed that these were well attended and issues were followed up in subsequent meetings. One resident spoken with said that while there was a suggestion box she much preferred to slip a note under the door of the person in charge as it was very important to go 'straight to the top' when needed; she also reported that she was a regular contributor giving feedback to the person in charge, who always responded, usually in person, to her queries.

New directional signage was installed following the last inspection. This provided guidance to rooms such as bedrooms, day and dining rooms and main reception to allay disorientation and confusion.

As part of reminiscence, extra large photo albums were created to display activity photos per month such as women's' little Christmas and newsletter for January; valentine's day celebrations and valentine's quiz in February and so on and the latest was the wine and cheese reception celebrating the residents art exhibition in June. The monthly newsletter that was displayed on each unit gathered together all the events and activities with photographs of the month for residents and visitors to recapture.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 25: Temporary absence or discharge of residents	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Nazareth House OSV-0000257

Inspection ID: MON-0040844

Date of inspection: 12/07/2023

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	Substantially 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: 04/09/23

A review of the staffing level, care needs and systems of work was completed to ensure supervision, medication rounds and appropriate care could be facilitated whilst ensuring that the Resident's rights to choose in relation to the various aspects of their care remains at the forefront. As part of the review the PIC and the CNM2 met with Dromore unit and Holy Family unit staff on 21/07/23 and discussed the findings of the inspection and agreed some practical solutions. The matters raised about the delivery of safe and effective care during twilight hours was one of the key points discussed. The following actions has since been agreed:

• There will now be three HCA's on duty until 21.00 hours. At the time of the inspection there were two HCA's on duty between the hours of 20.00 and 21.00
This is achieved through changing an 8.00 to 20.00 HCA shift to 09.00 to 21.00 shift. This change coupled with the changes to the medication round will ensure that the RGN will have protected time to complete her medication round before the third HCA finishes her shift.

• The GP has completed a full review of residents' medication and readjusted the medication administration time for selected and suitable residents. These changes do not include any night time sleeping tablets or specific antipsychotic medications. The above review has significantly decreased the medication administration workload for night Nurses. This allows the night nurse to provide enhanced care and supervision of residents during the twilight hours as her medication round would be completed in advance of the revised 21.00 hour day HCA's finish time.

• PIC and the unit CNM will continue to keep these arrangements under review and make any changes or improvements required to ensure the appropriate care and supervision of residents at all times especially during twilight hours.
Additional staffing will be provided as and when required on a short term basis to maintain a good quality and safe delivery of care.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Registered Provider will come into compliance with Regulation 23 by: 31/09/23 and the following actions have been completed:

• We have reviewed our audit plan post inspection and developed an enhanced audit schedule.
• A review of audit tools has been conducted and enhanced audit tools will be used to ensure maximum efficiency of our quality management program
• A specific division between collection of key performance indicator data and audits will be ensured.
• The array of questions within the audits will be redesigned to ensure a comprehensive evaluation
• Twilight hours staffing levels on Dromore and Holy Family have been reviewed and to ensure effective supervision, safe medication practice or appropriate delivery of care. Details are highlighted under Regulation 15 (Staffing) action plan.
More frequent simulated fire safety evacuations of compartments are now conducted outside of training to assure of fire safety precautions.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The Registered Provider will come into compliance with Regulation 31 by: 04/08/23
The following actions have been completed:
• The person in charge and people participating in management are fully committed to ensure that all statutory notifications are submitted within the required time frame specified in the regulations
• In addition to PIC there are 3 more management staff who have access to HIQA's online portal for the purpose of submitting notifications in a timely manner
• Ongoing trainings are being provided to staff to ensure that all notifiable events are reported and recorded in timely fashion.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
The Registered Provider will come into compliance with Regulation 18 by: 31/08/23

• The choice of having breakfast in the dining room is afforded to all residents
• The main meal of the day (Lunch) is now served at 12.30 mid-day
• PIC is committed to respect residents right to decide their mealtimes and where they wish to have their meals (bedroom or dining room)
• The practice will be monitored regularly to ensure compliance.

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:
The Registered Provider will come into compliance with Regulation 25 by: 31/08/23

• PIC will make sure that when a resident is transferred to another institute, the transfer letter contains full information to ensure the resident can be cared for in accordance with their assessed needs.
• PIC will ensure that discharge letter of short-stay residents to the public health nurse provides sufficient information to direct public health to appropriately manage care of the resident following discharge back to the community.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The Registered Provider will come into compliance with Regulation 28 by: 30/09/23
• Weekly simulations of evacuations of compartments in the centre including large compartments containing up to 10 and 13 residents are now being scheduled and have been in place since the week of the inspection. Once all compartments are covered through these simulations, the frequency will be changed to monthly.
• 14 staff with outstanding fire safety refresher training are scheduled for training on 6th and 15th of September 2023
• Personal emergency evacuation plans are being reviewed to ensure assessments are

accurate for each individual and that the appropriate support is in place in the event of an emergency evacuation.

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 05 by: 30/09/23
• We have completed an assessment and care plan work shop for nurses and CNMs on 03/08/23.This is the first work shop in a series of workshops to be completed in relation to assessment and care planning
• We also have developed an assessment and care plan standard operational procedure (SOP) to guide nurses to complete assessment and care plans effectively
• Care plans will be audited on a regular and structured basis to make sure that the deficiencies are identified and corrective actions taken in a timely manner

All residents' assessment and care planning are being formally evaluated to ensure the effectiveness. This formal evaluation and follow up actions will help to ensure that;
• assessments and care plans are comprehensively completed and has information to inform the care planning process to enable individualised care delivery
• residents' medical history taken into account to inform assessment or care planning to enable the resident to be cared for in accordance with their medical needs
• Wound care is assessed appropriately and care planning implemented to enable best outcomes for residents
• wounds care plans are discontinued when the wound healed
• any resident with pressure ulcer have a care plan to inform their care
• any resident on pain medication have a pain management care plan to enable assessment of the effectiveness of pain medication
• when 'as required' PRN medication is administered the reason for the medication administration are detailed to enable staff monitor a resident's pain and the effectiveness of the medication
• safeguarding plans are referencing the actions to be taken regarding known safeguarding concerns
• social support activity plans have details of the activities to enable follow up and inform the ongoing individualised activity programme
• behavioral support plans are comprehensively completed to include details of resident's underlying emotional state.

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.	Substantially Compliant	Yellow	04/09/2023
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Substantially Compliant	Yellow	31/08/2023
Regulation 18(2)	The person in charge shall provide meals, refreshments and snacks at all reasonable times.	Substantially Compliant	Yellow	31/08/2023
Regulation 23(c)	The registered provider shall ensure that management	Substantially Compliant	Yellow	30/09/2023

	systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 25(1)	When a resident is temporarily absent from a designated centre for treatment at another designated 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.	Substantially Compliant	Yellow	31/08/2023
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	30/09/2023
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are	Substantially Compliant	Yellow	30/09/2023

	aware of the procedure to be followed in the case of fire.			
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Orange	04/08/2023
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Not Compliant	Orange	30/09/2023
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	Substantially Compliant	Yellow	30/09/2023

	that resident's family.			