



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

Issued by the Chief Inspector

Name of designated centre:	Nephin Nursing Home
Name of provider:	Willoway Nursing Home Limited
Address of centre:	132 - 134 Navan Road, Cabra, Dublin 7
Type of inspection:	Unannounced
Date of inspection:	07 July 2021
Centre ID:	OSV-0005880
Fieldwork ID:	MON-0033516

About the designated centre

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

Nephin House is a purpose built facility and has a combination of single and shared accommodation over three floors. There are two elevators servicing the building. Once the centre is fully operational it can accommodate 62 residents. There is an enclosed garden area located to the rear of the building which is accessible from the large dining room. Nephin House is situated on the busy Navan Road, and a variety of bus routes stop close by. Prior to admission to Nephin House, the resident is fully assessed by the director of nursing. A range of activities are provided which encourage residents to keep mobile and take an interest in life. Outings to the nearby community parks can be arranged. Full time nursing care is provided, for residents with needs that range from mild dependency to full dependency.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	53
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This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 7 July 2021	09:05hrs to 17:55hrs	Michael Dunne	Lead

What residents told us and what inspectors observed

All residents who spoke to the inspector expressed high levels of satisfaction with the quality of their lives in the designated centre. A person centred approach was evident throughout the inspection with residents telling the inspector that “the staff know what I like to eat” and “ staff look after my medication for me”.

This was an unannounced inspection and on arrival the inspector was guided through the infection prevention and control measures necessary on entering the designated centre. A pre inspection meeting was then held with the director of nursing who was advised of the format of the inspection indicating the regulations that would be reviewed. A request for information and records relating to the management and monitoring of the designated centre was given to the director of nursing who provided the required information without delay at various intervals throughout the day.

The designated centre was located in North Dublin near to the Navan Road. The premises consisted of a basement and three floors which provided accommodation to the residents. The floors were named by the residents living in the centre with the ground floor called O' Connell, the first floor called Halfpenny and the second floor called Grafton. At the time of the inspection there were 53 residents living in the centre. The centre was well maintained with the layout of the floors suitable for the needs of the residents. Resident rooms were clean, tastefully furnished with suitable furniture available for residents to use. All bedrooms seen had a lockable facility in place for residents to store their personal items and sufficient wardrobe storage space to store their clothes. Some bedrooms had a full ensuite with toilet, hand basin and shower while others contained a toilet and wash basin only.

The inspector met with residents throughout the day and visited all three floors of the centre. Residents were observed to be well dressed wearing appropriate clothing and footwear. Mobility equipment used by residents and stored in designated areas was found to be well maintained and clean. Residents who sought staff attention by means of a call bell were seen to be attended to in a timely manner. Residents appeared content with a peaceful atmosphere maintained by the staff team.

Residents who spoke to the inspector expressed praise for the staff looking after them. Staff were seen conversing with residents in a manner supportive of resident's communication needs. Staff entering resident rooms were seen to announce their arrival by knocking on the resident's door and explaining the purpose of their visit.

On other occasions residents were seen supported by staff attending a meal service and attending an arts activity session. There were appropriate numbers of staff present to meet the needs of the residents in these areas.

The next two sections of the report will present findings in relation to governance and management arrangements in the centre and on how these arrangements

impacted on the quality and safety of the service being delivered.

Capacity and capability

The governance arrangements in the designated centre were well defined with individual roles and responsibilities clearly identified within the management structure. There were good levels of oversight at all levels which ensured that the quality and safety of care services was consistent and in line with the centres statement of purpose. The registered provider was eager to ensure compliance with the regulations and to provide a quality service to the residents. The inspector noted that some improvements were needed to ensure that this objective was achieved.

Nephin nursing home is operated by Willow Way nursing home limited and is registered to provide 62 bed spaces. This inspection was an unannounced risk inspection and was carried out to assess compliance with the Health Act 2007.

The person in charge was in post for three years and was supported in their day to day role by two clinical nurse managers while a company director and a person participating in management were also available and provided ongoing management support. There were meetings held regularly to review key information pertaining to the centre and included meetings which reviewed key performance indicators relating to clinical governance.

There were good levels of oversight seen to be conducted at different levels in the designated centre. For example daily inputs were reviewed at handovers while key information about the service was discussed and reviewed at internal management and at senior management governance meetings. The centre was sufficiently resourced to meet the needs of the residents and an annual review of quality and safety was in place for 2020

The inspector reviewed the quality management plan for 2021 which included a list of clinical audits assigned to staff to be completed throughout the year. Audits were assigned locally according to each staff' members key area of responsibility. While audits were in place and actions detailed to improve service areas, care plan audits did not identify that end of life and social care plans were not in place. The omission of these care plans meant that resident's last wishes were not clearly described or known by the staff team and therefore there was a risk that resident's last wishes may not be adhered to.

Similarly while there was information available to the centre accessed from "key to me" assessments this information was not used to formulate a care plan which would identify clearly the required activity interventions to meet residents assessed needs. This meant that residents were at risk at not being provided with activities according to their choice and levels of interest.

There was however a stable staff team in place who knew the residents needs very

well and this was evident on the day of the inspection. Residents spoke highly of staff and mentioned that they were caring and kind. Staff had received mandatory training along with Infection, prevention and control training which they said they found useful in their day to day work. There was evidence seen throughout the day that staff were able to adhere to measures to control the risk of infection spread. All staff were seen to wear appropriate PPE and were seen to carry out effective hand hygiene techniques.

There was a directory of residents maintained in the centre which was made available to the inspector. The directory was up to date and reflected the current status of residents living in the centre.

A complaints policy was available for residents and their relatives to use should they wish to register a complaint. The complaints process was well known to staff and residents with residents stating they felt comfortable registering a complaint if required. There was evidence that management reviewed complaints on a regular basis in order to improve the overall service to the residents.

Regulation 15: Staffing

The provider had ensured that there was sufficient numbers of staff rostered with the required skill mix to meet the needs of the residents living in the designated centre. The numbers of staff working on the day of the inspection was consistent with the staff resources identified on the rosters.

Judgment: Compliant

Regulation 16: Training and staff development

Staff records confirmed that staff working in the designed centre were appropriately supervised. There was an induction and appraisal system in place to support staff and guide staff during their employment. Staff had regular access to training and those staff spoken with were familiar with the Health Act 2007. Staff records confirmed that staff were current with their mandatory training which included fire safety, moving and handling and safeguarding training.

Judgment: Compliant

Regulation 19: Directory of residents

There was a directory of residents maintained in the designated centre which was

made available to the inspector to review. The directory included all the information required as specified in paragraph 3 of schedule 3 of the regulations

Judgment: Compliant

Regulation 22: Insurance

The provider had an insurance contract in place which provided cover to residents in the event of injury and loss or damage to resident's property.

Judgment: Compliant

Regulation 23: Governance and management

Systems to review the quality and safety of care provided to residents required improvement. While the centres own auditing systems indicated that care planning paperwork required updating it did not capture the absence of end of life or activity care plans within the care planning framework. This had not been identified by the management team.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was a complaints policy in place which was available to residents and relatives. The complaints procedure was advertised in a prominent location in the designated centre and met the requirements of the regulations. The registered provider was keen to learn lessons from complaints to improve the overall service. Of the seven complaints seen on the register six had been closed off with the satisfaction levels of the complainant recorded. One complaint was still open on the system however there was evidence to show that the provider had engaged proactively in trying to resolve this complaint.

Judgment: Compliant

Quality and safety

Residents well-being and welfare was maintained by a good standard of evidence based care and support. Residents told the inspector that they enjoyed living in the centre and that they felt safe and secure. Residents said that they felt listened to and that their views and comments were taken seriously by the provider. Improvements were required to ensure all resident care needs were assessed and provided for. Areas for improvement are described under regulation 5 and regulation 23 and are discussed in more detail in the capacity and capability section of this report.

Resident health care records were well maintained with referrals made for specialist input when required. A range of validated nursing tools were in use to identify resident health care needs which were reviewed on a regular basis by the clinical team. Relationships with health care providers were maintained to provide ongoing input for residents with access to occupational therapy, dietitian, speech and language therapy and tissue viability nursing input made on a referral basis.

Although there were no social activity care plans in place residents said they enjoyed the support staff provided regarding activities. Residents living on the first floor told the inspector that they were often supported to attend activities located on the ground floor which could accommodate larger groups. Other residents mentioned that they could attend activities provided more locally on their own individual unit or in their bedroom if they wished.

The registered provider promoted resident rights by accessing their views on the service provided in resident meetings and through one to one engagement. There was an advocacy service available for residents to use should they require it. All staff had safeguarding training in place and were aware of the contents safeguarding policy and procedure and how it could be used to promote an abuse free environment. Residents were supported to maintain links with their families during the pandemic through the use of social media platforms. Visiting had resumed in the centre with visitors having to undergo a series of infection protocol checks before gaining admittance. Visitors to the centre were required to prebook their visit in advance.

The centre was a purpose built facility with the design and layout suitable to meet the needs of the residents. Communal areas were suitably furnished with residents also having access to outside garden areas which they were using on the day of the inspection. Residents were able to personalise their own bedrooms with many seen containing pictures of families and loved ones. Residents commented positively on the support they received from staff in maintaining their own bedroom environment. There were dining facilities located on each floor which were suitable for residents use. A dining service was observed by the inspector and found that residents were in receipt of the required levels of support to be able to enjoy the dining experience. Residents mentioned that they like the food on offer and had a choice of food available to them.

There was a risk management policy and risk register in place which identified risks known to the centre. Records regarding risk were well maintained and complied with the requirements of the regulations. The safety and welfare of the residents living in

the centre was promoted and kept under review by the management team.

Precautions to prevent the risk of fire in the designated centre were in place. Fire safety monitoring records were well maintained with all staff having the mandatory fire safety training in place. The inspector saw examples of fire drills and evacuation records.

The designated centre had procedures in place for the prevention and control of health care associated infections which included a COVID-19 contingency and preparedness plan. The centre experienced an outbreak of COVID-19 from the 28 April 2020 until its closure on the 15 June 2020. During this time 28 residents and 23 staff were affected, sadly one resident passed away during this period.

The Inspector observed that robust arrangements were in place for the prevention of infection entering the designated centre. Measures to ensure appropriate hand hygiene, the donning and doffing of PPE and social distancing were seen to be maintained throughout the day. There was signage available in key locations to remind people of these measures. Regular infection, prevention and control audits combined with daily walk rounds by management ensured that these measures were maintained in the centre.

Regulation 17: Premises

The premises consisted of four floors with residents accommodated on the ground, first, and second floors. There were two lifts available for residents and staff to access the different floors. The centre was well maintained, clean and odour free. Residents told inspectors that they enjoyed their room space and also had opportunities to access their designated centres garden areas. The inspector noted that corridors and key exit routes were clutter free with mobility equipment stored in designated areas

Judgment: Compliant

Regulation 26: Risk management

There was a risk management policy in place which was due for review in 2023. There was a comprehensive risk register which listed both clinical and operational risks known to the registered provider. Risk assessments identified actions and controls that the provider had in place to mitigate against these risks.

Judgment: Compliant

Regulation 27: Infection control

There were arrangements in place to ensure that infection, prevention and control was effectively monitored in the designated centre. The centre was clean and well maintained with cleaning records signed off by appropriate personnel. Cleaning staff were knowledgeable around correct cleaning technique and were aware of the key role they played in maintaining an infection free environment. There were hand hygiene sinks located on each floor and the inspector observed appropriate wearing and use of personal protective equipment (PPE). There was signage located throughout the centre reminding staff, residents and visitors of the correct measures to follow.

Judgment: Compliant

Regulation 28: Fire precautions

Up-to-date service records were in place for the maintenance of fire equipment, the fire alarm system and emergency lighting. Fire exits were clear with directional signage in place to assist evacuation in the event of a fire. The inspector saw evidence of fire drills and simulated evacuation taking place. There were personal emergency evacuation plans (peeps) in place for residents to guide staff in the most appropriate method to evacuate residents in the event of a fire. Staff were knowledgeable of the centres fire procedures and gave account of their specific role in the event of a fire emergency

Judgment: Compliant

Regulation 5: Individual assessment and care plan

The inspector found that there were assessments in place called key to me and meaningful activities which detailed relevant information to inform person centred care planning regarding residents specific preferences. While this information was captured in some care plans there was no specific care plan to capture residents social care needs. Daily progress notes made reference to resident's attendances at various activities however due to the absence of a detailed care plan it was difficult to review or evaluate if these interventions met the residents social care needs.

There were no end of life care plans in place for the residents care records reviewed. There was information available on the centres IT care systems indicating if there was a do not resuscitate (DNR) or a cardiopulmonary resuscitation order (CPR) order in place for residents. A separate folder was held on each unit containing DNR and CPR decisions however there was a lack of clarity among the

staff around resident's end of life wishes due to the absence of an end of life care plan. Prior to the completion of the inspection the person in charge showed the inspector documentation indicating that residents end of life preferences were being sought with the intention of incorporating this information into individual end of life care plans.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to a general practitioner (GP) who attended the centre on a regular basis. Referrals arrangements were in place regarding input from specialist care services such as psychiatry of later life and palliative care services. Resident care records confirmed contact and follow up with these services. There were a range of clinical audits carried out on a regular cycle to monitor and maintain resident's health. The registered provider had arrangements in place to ensure that clinical staff had access to a range of medical training to maintain their professional expertise.

Judgment: Compliant

Regulation 9: Residents' rights

There were facilities available for residents to enjoy activities on their own or in a group. On the day of the inspection residents were seen engaging in an arts activity and were supported by staff to participate with regard to their communication needs. Residents told the inspector that there were able to exercise choice in their daily routines and felt that this was respected by the staff team. Resident rooms contained televisions and radios and were tastefully decorated. The registered provider engaged residents in resident meetings and in daily contact. A resident newsletter informed residents of key events happening in the home. While there was a range of activities provided for residents to enjoy there were no respective care plans in place for social care activities.

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 15: Staffing	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 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Nephin Nursing Home OSV-0005880

Inspection ID: MON-0033516

Date of inspection: 07/07/2021

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider’s response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: A review of care plan auditing will be completed and education of the regulation in relation to care planning will be completed.	
Regulation 5: Individual assessment and care plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan: - A separate care plan on social activity will be completed on all residents - A review of the process around end-of-life preferences will be completed - A care plan in relation to end of life with preferences will be completed for residents approaching end of lifer	

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 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.	Substantially Compliant	Yellow	31/08/2021
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	31/08/2021