Health Information and Quality Authority
Regulation Directorate

Compliance Monitoring Inspection report
Designated Centres under Health Act 2007, as amended

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Nazareth House
Centre ID:	OSV-0000257
Centre address:	Dromahane, Mallow, Cork.
Telephone number:	022 215 61
Email address:	john.omahoney@nazarethcare.com
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Sisters of Nazareth
Lead inspector:	John Greaney
Support inspector(s):	Caroline Connelly
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	98
Number of vacancies on the date of inspection:	22

About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

Please note the definition of the following term used in reports:
responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

Compliance 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 inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
03 July 2019 09:15	03 July 2019 17:30
04 July 2019 09:00	04 July 2019 18:30

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Substantially Compliant	Substantially Compliant
Outcome 02: Safeguarding and Safety	Substantially Compliant	Non Compliant - Moderate
Outcome 03: Residents' Rights, Dignity and Consultation	Substantially Compliant	Substantially Compliant
Outcome 04: Complaints procedures	Compliance demonstrated	Compliant
Outcome 05: Suitable Staffing	Non Compliant - Moderate	Non Compliant - Moderate
Outcome 06: Safe and Suitable Premises	Compliance demonstrated	Substantially Compliant
Outcome 07: Health and Safety and Risk Management		Non Compliant - Moderate
Outcome 12: Notification of Incidents		Substantially Compliant

Summary of findings from this inspection

Nazareth House is a 120-bedded centre that was newly built adjacent to the pre-existing centre in 2018. It is located in a rural area on large grounds approximately five kilometres from Mallow town. For operational purposes the centre is divided into five units or "households". Three of the units have bedroom accommodation for thirty residents, while the other two have accommodation for fifteen residents. One of the fifteen-bedded units is the designated dementia unit. All of the bedrooms are single rooms with en suite shower, toilet and wash hand basin.

This inspection report sets out the findings of a thematic inspection which focused on specific outcomes relevant to dementia care in the centre. The inspection also considered notifications and other relevant information.

As part of the thematic inspection process, providers were invited to attend information seminars facilitated by the Office of the Chief Inspector. In addition, evidence-based guidance was developed to guide the providers on best practice in dementia care and the inspection process. Prior to the inspection, the person in charge completed the provider self-assessment and compared the service with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.
The person in charge assessed the centre as compliant in two of six outcomes, substantially compliant three outcomes and moderate non-compliant in one.

The journey of a sample of residents with dementia within the service was tracked. The inspector reviewed documentation such as nursing assessments, care plans, medical records and examined relevant policies including those submitted by the centre prior to this inspection as part of their self-assessment process. The inspector observed care practices and interactions between staff and residents who had dementia using a validated tool. All interactions and care practices by staff with residents, as observed by inspectors were person-centred, therapeutic, respectful and kind.

Inspectors found that the management team and staff were committed to providing a quality service for residents with dementia and were working to ensure the service was provided to a high standard. A person-centered approach to care was observed. Residents appeared well cared for and it was evident that independence was promoted. The inspector met with the residents, some of whom had advanced dementia. The inspector also spoke with family members of residents who had dementia. The feedback was predominantly positive.

There were adequate numbers and skill mix of staff to meet the care needs of residents. A staff recruitment, induction, supervision and training programme was in place, however, some improvements were required. For example, records of induction were not adequate to demonstrate that staff were adequately supervised and assessed during induction. Additionally, the requirements of Schedule 2 of the regulations in respect of Garda vetting and employment references were not always in place prior to staff commencing employment. There were gaps in mandatory training and not all staff had attended up-to-date training in fire safety, safeguarding residents from abused and manual and people handling. A review was also required on dementia training to ensure that it was adequately comprehensive in respect of training in responsive behaviour.

The inspector observed numerous examples of good practice in areas examined which resulted in positive outcomes for residents. The results from the formal and informal observations were positive and staff interactions with residents were caring and kind. The living environment has significantly improved and now affords residents privacy and dignity throughout the day. There was ample communal space

for residents and also there was access to safe outdoor areas. The general décor was of a high standard. The environment could be enhanced through the provision of improved signage to support residents with a cognitive impairment navigate the centre. The addition of memorabilia relevant the resident population would also enhance the environment.

Residents had access to their general practitioner and other therapeutic services relevant to their needs. Care plans were person-centred and guided staff in meeting the residents' care needs.

The Action Plan at the end of this report identifies the areas where improvements are required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centre's for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland 2016.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
This outcome sets out the inspection findings relating to healthcare, assessments and care planning. The social care of residents with dementia is discussed in Outcome 3. The inspector focused on the experience of residents with dementia and tracked the journey of a number of residents with dementia.

Of the 98 residents in the centre on the days of the inspection, 26 had a formal diagnosis of dementia and all but one of these residents were over the age of 65 years. Another 14 residents had some degree of cognitive impairment were suspected of having dementia but did not have a formal diagnosis.

Residents were predominantly admitted from acute hospitals but some were also admitted directly from their home or transferred from another centre. A pre-admission assessment was not usually carried out prior to admission. Instead the centre relied on information supplied by the discharge coordinator from the acute hospital and also from information contained in a common summary assessment report (CSAR). The CSAR is usually completed in the acute hospital and is a summary report of the health and social care needs of potential residents.

Residents had access to general practitioners (GPs) of their choice. Medical notes indicated that residents were reviewed regularly by their respective GPs. Residents with dementia were supported to attend out-patient appointments and were referred as necessary for care in the acute hospital services. There were records available showing that information was shared between the centre when residents were transferred to hospital or discharged to the centre.

There was good access to allied health services and there was evidence of referral and review. Systems were in place for residents to have regular reviews by dental and optician services. Systems were also in place to ensure that residents that qualified for national screening programmes were facilitated to participate in the programme, should they so wish.

Nursing records were maintained predominantly in electronic format. Comprehensive nursing assessments were carried out that incorporated the use of validated assessment tools for issues such as the risk of falling, risk of developing pressure sores and for the risk of malnutrition. Care plans were developed using the activities of daily living model. A sample of care plans reviewed contained the required information to guide care delivery. Overall, care plans were person-centred and were updated regularly to reflect changing care needs. The inspector found that staff knew residents well and were knowledgeable regarding residents' likes, dislikes and their individual needs. There was a system in place to ensure that the resident and their families were consulted in relation to the development of the care plan.

Staff provided end-of-life care to residents with the support of their GP and community palliative care services, as required. The inspectors viewed the record of a resident that was under the care of the palliative care team. There was evidence of discussion around end of life preferences, including treatment preferences in the event of cardiac arrest or a gradual deterioration in the resident's health status. All residents were accommodated in single rooms, which supported residents to have privacy and dignity at end of life. Residents' relatives were facilitated to stay overnight with them when they became acutely ill and there were tea and coffee making facilities for relatives. Religious and cultural needs were facilitated. There was mass in the centre each day and members of the local clergy provided pastoral and spiritual support to residents as they wished. There was a large church in the centre, however, this was inaccessible to residents at the time of the inspection, as that area of the centre was undergoing renovations and redecoration.

The nutrition and hydration needs of residents with dementia were assessed and monitored. A validated assessment tool was used to screen residents for nutritional risk on admission and regularly thereafter. Residents' weights were checked regularly with an increase in the frequency of weights for those residents that were identified as at risk of malnutrition. Nutritional assessments and care plans were in place that outlined the recommendations of the dietician and speech and language therapists, where appropriate.

While there was a choice of food available, there was some inconsistency in relation to the availability of choice in the different units in the centre. In some units, all residents were offered choice, while in others, choice was not always offered to residents prescribed Texture C diet (smooth, moist and lump free). Additionally, the diet sheets used to ascertain each resident's choice at mealtimes did not always use the appropriate terminology, such as Texture A, B, or C and instead the word soft was used, predominantly for Texture C diets, but on occasion for Texture B diets (minced and moist).

A discussion with catering staff indicated that they had a personal knowledge of individual residents likes and dislikes. Food was attractively presented and residents requiring assistance at mealtime were assisted in an appropriate manner by staff.

There was a centre-specific medication policy with procedures for safe ordering, prescribing, storing and administration of medicines. All residents had photographic identification in place. Prescriptions were typed, clearly legible and all were signed by a

medical practitioner. Medications in the centre were supplied in a monitored dosage system. There was a system of reconciliation to ensure that what was delivered matched the prescription.

The supply and administration of scheduled controlled drugs was checked and was correct against the drug register, in line with legislation. Two nurses checked the quantity of these medications at the start of each shift. Nursing staff spoken with by the inspectors displayed a good knowledge of the requirements in the area of controlled drugs and the responsibilities of the registered nurse to maintain careful records.

Judgment:
Substantially Compliant

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
There was a policy and procedure in place to inform the prevention, detection and response to any allegations, disclosures or incidents of abuse in the centre. Staff were facilitated to attend training on recognising and responding to suspicions or allegations of abuse, however, not all staff had attended this training. Staff spoken with by inspectors demonstrated a good knowledge of what constituted abuse and what to do in the event of suspicions of abuse. Residents told the inspector that they felt safe in the centre and spoke positively about the staff caring for them. All interactions by staff with residents observed by inspectors were kind and respectful.

Improvements were required in relation to recognising and responding to allegations of abuse. A review of the complaints log identified that some complaints would have been more appropriately investigated under the safeguarding policy rather than as a complaint. These related to a small number of incidents in which interactions by some staff with residents, from the resident's perspective, could be perceived as abuse of a psychological nature. While these issues were addressed, if they had been investigated according to the safeguarding policy, enhanced safeguarding arrangements would have been put in place during the investigative process.

There were systems in place for the management of residents' finances. The inspector was informed that the provider was pension agent for eight residents. The procedures in place for managing finances were reviewed and the inspector found that satisfactory records were maintained. Small sums of money were held on behalf of residents and receipts were available for all transactions made on behalf of residents.

There was a policy and procedure in place for the management of responsive behaviour. The inspectors were told that a small number of residents with dementia were predisposed to experiencing responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

A policy to inform management of restraint was available and reflected procedural guidelines in line with the national restraint policy. Improvements were noted in the use of restraint, with reductions in the number or residents using bedrails since the previous inspection. Safety checks were carried out for residents when bedrails were in place. The pharmacist reviewed the use of psychotropic medications on a regular basis.

Judgment:
Non Compliant - Moderate

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Inspectors found that residents, including residents with dementia, were consulted about how the centre was run and were enabled to make choices about their day-to-day life in the centre. There were adequate arrangements in place for consultation with relatives and families, who said they were regularly asked for their views in relation to their relatives' care and the service provided. There were residents' meetings held monthly and the venue was rotated to a different unit each month. Residents were also consulted on a one-to-one basis.

Inspectors observed that staff interacted with residents throughout the day, while also respecting their privacy. Residents were able to exercise choice in relation to the time they got up and went to bed and told the inspector they were able to have breakfast at a time that suited them.

Inspectors spent five periods of time observing staff interactions with residents. A validated observational tool, the quality of interactions schedule (QUIS) was used to rate and record at five minute intervals the quality of interactions between staff and residents in the communal sitting areas and dining rooms. Inspectors observed that staff knew residents well and engaged with them in a personal, meaningful way by asking about their wellbeing, plans for the day, activities and meals. Inspectors observed that all residents had good levels of social engagement that appeared to provide them with enjoyment. Residents told inspectors that they had good relationships with staff and found them very helpful.

Social care opportunities were provided daily by two designated activity staff. There was a good level of activities, both within and outside of the centre. There was a large noticeboard in each of the units outlining for residents the activities available on that particular day. Inspectors reviewed the activity programme. While the programme was varied, it could be enhanced by the inclusion of activities targeted to the needs of people with dementia. The programme of activities started each day with Mass at 10am, followed by tea and coffee. This was followed by sessions of light group exercises in each of the units and then some one-to-one activities for those residents that did not wish to participate in group exercises or liked to spend more time in their bedrooms. Activities in the afternoon were more varied and included Boccia, flower arranging, bingo, and sing-a-longs. Residents also participated in group activities such as a percussion group, line dancing and a choral group. There were good links with the community through outings twice weekly to local amenities in transport provided by the Irish Wheelchair Association and a local community bus.

The activities staff were supported by a number of volunteers. There was a small shop on site that was operated by the volunteers. Volunteers also led some of the group activities, such as the choral group.

During main meal times, staff were observed to offer assistance in a respectful and appropriate manner. All staff sat beside the resident they were assisting and were noted to encourage the resident throughout their meal. Independence was promoted and residents were encouraged to eat their meal at their own pace, with minimal assistance to improve and maintain their functional capacity. Adequate time was allocated to mealtimes and residents were observed to take as much time as they wished over their meals.

Inspectors were informed that the returning officer visited the centre and residents were facilitated to vote in local and European elections and in the referendum.

Judgment:
Substantially Compliant

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

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

Findings:
There was a complaints procedure in place. The inspectors found that any complaints made in the centre were listened to and acted upon in a timely manner. Information advising residents and others about how to complain was described in the residents'

guide, the statement of purpose and the procedure was on display. The person in charge was responsible for addressing complaints.

Inspectors spoke with a number of residents who confirmed that they were aware of the procedure in relation to making a complaint and would feel confident to do so, if needed.

Inspectors reviewed the complaints log. A record was kept of all complaints. Complainants were updated promptly of the outcome of the investigation . All complaints were reviewed by the person in charge and areas for improvement and learning were identified and discussed at staff meetings.

Judgment:
Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

Findings:
The inspector observed staff providing care in a respectful manner. Residents appeared to be familiar with staff and were complimentary of the caring nature of staff.

An actual and planned roster was maintained in the centre, with any changes clearly indicated. There was a regular pattern of rostered care staff. Based on a review of the roster and the observations of the inspector, there were adequate numbers and skill mix of staff to meet the needs of the residents living in the centre on the days of the inspection.

Improvements were required in relation to the recruitment, induction, supervision and training of staff. A review of staff files indicated that the requirements of Schedule 2 of the regulations were not always met. Of the sample of staff files reviewed, all had evidence of identity and a full employment history, that included an explanation for any gaps. While all staff had Garda vetting in place, records indicated that at least one member of staff had commenced working in the centre before the vetting process had completed. It was also noted that references were not obtained prior to all staff commencing employment, with references for one member of staff dated in excess of two months after the staff member commenced employment. References for another staff member were not obtained from the person's most recent employer.

While there was an induction process in place for new staff, the induction record was not adequate and did not clearly indicate that staff had been adequately assessed in

relation to competency in performing the role for which they were recruited. The induction record was too general and required review so that the skills required for each role were assessed by a staff member deemed competent to do so.

While there was a system of staff appraisal, the system had lapsed and appraisals were not done on an annual basis as intended. In addition, the appraisal system was not utilised in instances where it was identified that some staff members may benefit from increased supervision or training.

A review of training records indicated that staff were facilitated to attend training in a range of topics, such as manual and people handling, fire safety, dementia care, safeguarding residents from abuse, medication management, and restraint. However, not all staff had attended up-to-date training on some of these areas that are considered mandatory such as manual and people handling, safeguarding residents from abuse and fire safety. Also, responsive behaviour was included in dementia training and inspectors were not satisfied that this training was of sufficient length to comprehensively cover both of these topics.

Judgment:
Non Compliant - Moderate

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Nazareth House is a 120-bedded centre that was newly built adjacent to the pre-existing centre in 2018. It is located in a rural area on large grounds approximately five kilometres from Mallow town. For operational purposes the centre is divided into five units or "households". Three of the units have bedroom accommodation for thirty residents, while the other two have accommodation for fifteen residents. One of the fifteen-bedded units is the designated dementia unit. All of the bedrooms are single rooms with en suite shower, toilet and wash hand basin.

Corridors are wide and have handrails on both sides. There is suitable floor covering and no trip hazards. In addition to en suite facilities there are toilets located proximal to communal rooms for ease of access by residents. There is also a bathroom with an assisted bath on each unit.

There is a large sitting room and large dining room in each of the units. There is a quiet room in each unit for residents to spend some time alone or to meet with visitors, separate from their bedrooms. There are also other areas along corridors with seating

for use by residents.

Bedrooms are adequate in size for residents with a comfortable chair, a desk, bedside locker with a lockable drawer, and a large wardrobe in each room. All bedrooms, bathrooms and communal rooms are fitted with call bells. There are a number of secure outdoor areas that are readily accessible to residents on the ground floor. One of the outdoor areas is a large internal courtyard that has a number of paved footpaths that facilitates residents to have long walks. All of the outdoor areas are landscaped to a high standard. There are ample storage facilities in each unit to store assistive equipment such as hoists and wheel chairs.

From a dementia perspective the centre could be enhanced through improved signage to orient residents to the centre. The décor, while of a high standard, was somewhat clinical in nature and did not provide for a homely atmosphere. The environment could also be enhanced through the addition of memorabilia relevant to the profile of residents living in the centre.

Judgment:
Substantially Compliant

Outcome 07: Health and Safety and Risk Management

Theme:
Safe care and support

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

Findings:
In the context of health and safety, some issues were identified by inspectors during a walk around of the centre. Renovations of the pre-existing centre were underway and workmen were on site. Inspectors noted that access to the area undergoing renovations was not adequately secured from access by residents, where they could become exposed to dangerous equipment or substances. It was also noted that in the new centre, residents had free access to stairwells. The provider and person in charge were advised to carry out a risk assessment to ascertain if access to stairwells by residents posed a risk to their health and safety.

Some improvements were also required in relation to fire safety. Quarterly preventive maintenance of the fire alarm and emergency lighting had not been carried out. It was noted during the walk around that some equipment had been stored in an emergency exit stairwell. While this equipment did not cause an obstruction, areas such as this are recommended to be kept sterile. It was also observed that some fire extinguishers were obstructed by chairs.

Judgment:

Non Compliant - Moderate

Outcome 12: Notification of Incidents

Theme:
Effective care and support

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

Findings:
A review of records indicated that not all notifications required to be submitted to the Chief Inspector were submitted as required. This included incidents where there were suspicions or allegations of abuse or incidents of misconduct by staff members.

Judgment:
Substantially Compliant

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

John Greaney
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Nazareth House
Centre ID:	OSV-0000257
Date of inspection:	03/07/2019
Date of response:	06/08/2019

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The diet sheets used to ascertain each resident's choice at mealtimes did not always use the appropriate terminology, such as Texture A, B, or C and instead the word soft was used, predominantly for Texture C diets, but on occasion for Texture B diets (minced and moist).

1. Action Required:

[1] The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

Under Regulation 18(1)(c)(iii) you are required to: Provide each resident with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.

Please state the actions you have taken or are planning to take:
New Diet Sheets will be introduced which will require the mandatory inclusion of appropriate terminology such as Texture A or B or C or D.

Proposed Timescale: 30/08/2019

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
While there was a choice of food available, there was some inconsistency in relation to the availability of choice in the different units in the centre. In some units, all residents were offered choice, while in others, choice was not always offered to residents prescribed Texture C diet (smooth, moist and lump free).

2. Action Required:
Under Regulation 18(1)(b) you are required to: Offer choice to each resident at mealtimes.

Please state the actions you have taken or are planning to take:
Meetings with Clinical Nurse Managers of each unit and the Catering Manager have been held to review the current practices and agree a consistent approach in each unit to provide choice for all Residents (all consistency diets).

In some situations, the resident may be unable to verbalise choice, when menu picture cards will be provided to aid residents to make a choice. Where the menu picture cards are not effective with an individual resident, choice will be decided by the staff based on the resident's known likes and dislikes.

Proposed Timescale: 30/09/2019

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Improvements were required in relation to recognising and responding to allegations of abuse. A review of the complaints log identified that some complaints would have been more appropriately investigated under the safeguarding policy rather than as a

complaint. These related to a small number of incidents in which interactions by some staff with residents, from the resident's perspective, could be perceived as abuse of a psychological nature.

3. Action Required:
Under Regulation 08(3) you are required to: Investigate any incident or allegation of abuse.

Please state the actions you have taken or are planning to take:
1. All incidents or allegations of abuse are investigated.
2. A thorough review of all complaints has been completed and either an NF06 or NF07 as appropriate will be submitted.
3. Allegations of abuse will be investigated under the safeguarding policy rather than as a complaint and a NF06 or NF07 will be submitted as per the Statutory Notifications16 Guidance for Registered Providers of Designated Centres (Health Information and Quality Authority, January 2016).

Proposed Timescale: 16/08/2019

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Staff were facilitated to attend training on recognising and responding to suspicions or allegations of abuse, however, not all staff had attended this training.

4. Action Required:
Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

Please state the actions you have taken or are planning to take:

Proposed Timescale:

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
While the programme of activities was varied, it could be enhanced by the inclusion of activities targeted to the needs of people with dementia.

5. Action Required:

Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

Please state the actions you have taken or are planning to take:
The Provider will provide additional opportunities for residents to participate in activities in accordance with their interests and capacities such as:

1. A Rummage Box will be provided in each unit to be utilised at any time of day by residents independently or assisted by staff where appropriate. (implementation date:30th September 2019).
2. A Personal Memory Box is being developed for Residents with Dementia which will enhance engagement, support communication, stimulate memory and the senses. (Implement Date: 31st October 2019 depending on family support for pictures etc.).
3. A new programme Mental Aerobics (Montessori based activity) will be implemented which enables Residents with Dementia to utilise their strengths and abilities, enhance orientation and engagement in meaningful activity, social connection. (Implement Date: 12th August 2019).
4. A Multi-Sensory Environment Room will be provided. (in progress Completion Date: 31st December 2019).
5. Sonas Programme. The activity co-ordinator has applied for a Sonas training programme and will introduce the Sonas Programme as soon as training is complete and certified.(Implement Date: 31st December 2019).
6. Music Alive Creative Enquiry Project which recognises the universal right to entitlement to participate in arts and culture. The arts have the potential to be transformative, to change and influence the attitudes and experiences of Residents. (Implementation Date: 30th August 2019).

Proposed Timescale: 31/12/2019

Outcome 05: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Improvements were required in relation to staff supervision. For example:
• while there was an induction process in place for new staff, the induction record was not adequate and did not clearly indicate that staff had been adequately assessed in relation to competency in performing the role for which they were recruited. The induction record was too general and required review so that the skills required for each role were assessed by a staff member deemed competent to do so
• while there was a system of staff appraisal, the system had lapsed and appraisals were not done on an annual basis as intended. In addition, the appraisal system was not utilised in instances where it was identified that some staff members may benefit from increased supervision or training.

6. Action Required:

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

Please state the actions you have taken or are planning to take:
1. A comprehensive new induction process has been developed and is operational. The continuous assessment of performance for new staff has also been updated.
2. Clinical Nurse Managers will be responsible for completing annual performance appraisal of all staff in their unit and following up on needs identified. This process will be audited by the Assistant Director and Director of Nursing to ensure compliance.

Proposed Timescale: 15/08/2019

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A review of training was required. For example:
• not all staff had attended up-to-date training on some of these areas that are considered mandatory such as manual and people handling, safeguarding residents from abuse and fire safety
• responsive behaviour was included in dementia training and inspectors were not satisfied that this training was of sufficient length to comprehensively cover both of these topics.

7. Action Required:
Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

Please state the actions you have taken or are planning to take:
1. The training matrix is now being transferred to a new IT system which will highlight for Director of Nursing any training outstanding at a glance.
2. Dates have been scheduled for all mandatory training outstanding and has already commenced.
3. The Dementia Training programme has been expanded to a full day session per person.

Proposed Timescale: 31/12/2019

Theme:
Workforce

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Improvements were required in relation to the recruitment, induction, supervision and training of staff. For example:
• records indicated that at least one member of staff had commenced working in the

centre before the vetting process had completed
• references were not obtained prior to all staff commencing employment, with references for one member of staff dated in excess of two months after the staff member commenced employment
• references for another staff member were not obtained from the person's most recent employer.

8. Action Required:
Under Regulation 21(1) you are required to: 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.

Please state the actions you have taken or are planning to take:
1. New staff will not be allowed commence work until all criteria of Schedule 2 - Regulations 15 and 15 of SI No.293 of 2016 is met and deemed satisfactory.
2. The Director of Nursing / Assistant Director of Nursing will phone check on the reference from most recent employer. This reference from the previous employer will be required to be signed by a Senior Member of Management / Human Resource Manager.

Proposed Timescale: 01/08/2019

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
From a dementia perspective the centre could be enhanced through improved signage to orient residents to the centre. The décor, while of a high standard, was somewhat clinical in nature and did not provide for a homely atmosphere. The environment could also be enhanced through the addition of memorabilia relevant to the profile of residents living in the centre.

9. Action Required:
Under Regulation 17(1) you are required to: 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 under Regulation 3.

Please state the actions you have taken or are planning to take:
The décor of the units will be reviewed to provide for a more homely atmosphere. The environment will also be enhanced through the addition of memorabilia relevant to the profile of residents living in the centre and in accordance with the statement of purpose.

Proposed Timescale: 30/11/2019

Outcome 07: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Improvements required in relation to health and safety included:
• renovations of the pre-existing centre were underway and workmen were on site. Inspectors noted that access to the area undergoing renovations was not adequately secured from access by residents, where they could become exposed to dangerous equipment or substances
• it was also noted that in the new centre, residents had free access to stairwells. The provider and person in charge were advised to carry out a risk assessment to ascertain if access to stairwells by residents posed a risk to their health and safety.

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

Please state the actions you have taken or are planning to take:
1. The renovations of the pre-existing centre are now completed and there are no longer areas where dangerous equipment or substances exist.
2. A risk assessment, by the provider and person in charge, to ascertain if access to stairwells by residents posed a risk to their health and safety has been completed and it was determined to install key-code access in the three remaining stairwells.

Proposed Timescale: 30/11/2019

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Quarterly preventive maintenance of the fire alarm and emergency lighting had not been carried out.

11. Action Required:
Under Regulation 28(1)(c)(i) you are required to: Make adequate arrangements for maintaining all fire equipment, means of escape, building fabric and building services.

Please state the actions you have taken or are planning to take:
Maintenance Contracts are now in place to carry out quarterly preventive maintenance of the fire alarm and emergency lighting in accordance with Regulation 28(1)(c)(i).

Proposed Timescale: 09/08/2019

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
It was noted during the walk around that some equipment had been stored in an emergency exit stairwell. While this equipment did not cause an obstruction, areas such as this are recommended to be kept sterile. It was also observed that some fire extinguishers were obstructed by chairs.

12. Action Required:
Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

Please state the actions you have taken or are planning to take:
A programme is now in place to check the emergency exit stairwells to ensure that equipment is not stored in these areas as well as monitoring the obstruction of fire extinguishers.

Proposed Timescale: 31/07/2019