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-0000149
Centre address:	Malahide Road, Clontarf, Dublin 3.
Telephone number:	01 833 8205
Email address:	maura.hooper@nazarethcare.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Sisters of Nazareth
Provider Nominee:	Maura Hooper
Lead inspector:	Nuala Rafferty
Support inspector(s):	Jim Kee; Shane Walsh
Type of inspection	Unannounced Dementia Care Thematic Inspections 2015
Number of residents on the date of inspection:	87
Number of vacancies on the date of inspection:	0

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.

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 Quality 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:
25 August 2015 09:30	25 August 2015 20:30
26 August 2015 06:00	26 August 2015 17:00

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	Non Compliant - Major
Outcome 02: Safeguarding and Safety	Substantially Compliant	Non Compliant - Moderate
Outcome 03: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate	Non Compliant - Moderate
Outcome 04: Complaints procedures		Compliant
Outcome 05: Suitable Staffing	Substantially Compliant	Non Compliant - Major
Outcome 06: Safe and Suitable Premises	Non Compliant - Moderate	Non Compliant - Major

Summary of findings from this inspection

This inspection report sets out the findings of a thematic inspection which focused on six specific outcomes relevant to dementia care. The purpose of this inspection was to determine what life was like for residents with dementia living in the centre. The inspection also considered progress on findings further to the registration follow up inspection carried out on 1 October 2013 and to monitor progress on the actions required arising from that inspection. This was an unannounced inspection conducted by three inspectors over one day and completed by one inspector on the second day.

The provider had submitted a completed self assessment tool on dementia care to the Authority with relevant policies and procedures prior to the inspection. This information identified that 39 of the 87 residents who were residing in the centre during the inspection had a formal diagnosis of dementia and a further 30 had a cognitive impairment. The centre did not have a dementia specific unit. The provider had assessed the compliance level of the centre as above, however, the findings of

inspectors did not accord with the providers judgements.

Some progress was made by the provider in implementing the required improvements identified on the follow up inspection in October 2013 but many of the findings at that time were again evident on this inspection.

Risks associated with standards of clinical care and supervision of practice, staffing levels and skill mix and unsuitable aspects of the physical environment were found. Major non compliances were found under Outcomes 1, 5 and 6, Moderate non compliance under Outcomes 2 and 3 and Outcome 4 was found to be compliant. All of the findings were discussed at length throughout the inspection with the provider nominee, person in charge and a recently appointed clinical nurse manager and at the end of inspection feedback meeting with the Chief Executive Officer for the Provider (Unincorporated Body- Sisters of Nazareth).

Due to the number and nature of recurrent findings and the level of major non compliances found, the provider was advised that immediate actions were required to mitigate the risks. A satisfactory written assurance was given to the lead inspector prior to the conclusion of the inspection that three additional nursing staff would be rostered on 12 hour day shifts from the day following the inspection on an ongoing basis to raise the standard of clinical care being delivered. The inspector was assured that this swift response would be implemented by the provider.
The Action Plan at the end of this report identifies 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 Quality Standards for Residential Care Settings for Older People in Ireland.

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 Quality 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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
A safe and suitable standard of care was not being delivered to all residents. The clinical care needs of all residents particularly those with a formal diagnosis of dementia or those with cognitive impairments were not being fully met.

Access to a medical and allied health professional was available. Residents were given the choice to remain with their own general practitioner on admission or transfer to one within a number of medical clinics operating locally. The majority of residents choose the latter as visits by the doctors from the local clinics were regularly made on referral or on a needs required basis. Evidence of access to allied health professionals was also found with documented visits assessments and recommendations by speech and language therapists; tissue viability nurse specialists and dietician reviews. The inspectors met several visiting doctors and a physiotherapist during the inspection. Private external dental, optical and podiatry services also routinely visited the centre to assess needs and treat where necessary.

Samples of clinical documentation including nursing and medical records were checked. This showed that all recent admissions to the centre were assessed prior to admission. Where people were admitted from the community a common summary assessment report was completed. The pre admission assessment was generally conducted by the person in charge who looked at both the health and social needs of the potential resident.

The arrangements to meet residents' assessed needs were set out in individual care plans and each resident had a care plan completed. A number of recognised assessment tools to check for risk of deterioration were used including; risk of falls, nutritional status, levels of cognitive impairment, skin integrity, pain, continence and communication. A number of care plans referred to family involvement in the care planning process, where family were consulted for decision making or to seek and give information relating to the resident. It was noted that where residents attended clinic appointments they were accompanied by a member of staff, relative or other responsible person. This helped to ensure transfer of information back to staff in the

centre. Results of investigations and discharge information from acute hospitals were available within residents' files.

A healthcare plan for every identified health or social care problem is required to be put in place by the nursing team to maintain residents' health and wellbeing and monitor improvements or deterioration. But it was found that care plans were not in place for all identified needs. Examples of healthcare needs, where care plans were not in place included; dementia; bipolar disorder, behaviour that challenges, risk of absconsion and depression. Also it was noted that where plans were in place, they were not always implemented.

A strong system to make sure healthcare plans reflected the care delivered and were amended in response to changes in residents' health was not in place. These plans were not being checked regularly to make sure they were detailed enough to maintain or improve a resident's health. The daily nursing progress notes did not always refer to changes in health care plans or changes to treatments or recommendations made by clinicians to give a clear and accurate picture of residents' overall health. It was also found that most although not all care plans were generic in nature and were not person centred.

Inspectors found there were negative impacts on residents' health and wellbeing as a consequence of this inadequate assessment planning and evaluation of care including;
- the nursing team was unaware of the nutritional status of all residents. Weights and MUST (malnutrition risk assessments) scores food preferences, nutritional supplements, food fortification or recommendations by dietician such as special diets were not always referenced in care plans. Where they were included, they were not always accurate and/or there was no evidence of being implemented. In a random selection of one third of all residents in the centre it was found that several residents had significant weight loss. In an eight month period from January to August body weight losses of 19%; 13.8%; 8.4%; 7.9% and 6.9% were found. In a four month period from April to August body weight losses of 17.5%; 12.9%; 12.6% and 4% were found.
- Care plans to maintain skin integrity and prevent, treat or otherwise manage pressure ulcer development were not detailed enough to guide healthcare staff. It was also found in conversations with many healthcare staff that they were not aware of the content of the care plans and were not receiving enough direction or supervision to inform their practice.
As a result a good standard of basic care was not being implemented. Evidence of this was found where residents identified as at risk of pressure ulcer development and who required assistance to reposition their body on a regular were not always receiving this care. The inspector was told variously by different staff on one unit that between one and three residents currently needed this care.
- Nursing staff were not correctly identifying the level of skin damage occurrence. The inspector was told that some were at Grade 2 but on checking the inspector found they were grade 4. This is a more serious level of ulcer and is very debilitating particularly for an older person.
- despite the number of residents with a formal diagnosis of dementia or those with a cognitive impairment. In a sample of care plans viewed, inspectors found that of seven persons with a formal diagnosis of dementia only two had care plans in place. There were several residents with history of showing signs of aggression, or were identified as

at risk of wandering or absconsion. Behavioural charts were in place for some of these residents but not all had a care plan in place and where they were in place were not updated.

- A high number of residents, approximately 60%, were identified as being at risk of falls and although risk assessments had been carried out, the majority had not been reviewed on a quarterly basis and some were as long as seven months since being last updated. This is of particular concern considering there were four falls which resulted in serious injuries to residents. Three sustained hip fractures and one sustained ankle fracture between May and August this year.

Clinical documentation did not provide evidence that sufficient care was being provided. Flow charts were not fully completed to show for example that skin integrity was maintained for those at risk of developing pressure ulcers. Nurses' daily progress records did not provide detail on the overall status of residents. The notes did not give any detail on the care delivered, signs of improvement or deterioration in physical emotional or psychological state. They did not indicate how the resident had spent their day. This meant that a general picture of each person's overall health and wellbeing could be not be determined.

Written operational policies relating to the ordering, prescribing, storing and administration of medicines were in place although some were not fully implemented in practice. Although nursing staff were observed to follow appropriate administration of medication to residents in the dining room during lunch while checking the management and administration of psychotropic and sedative medications, inspectors found reference to a sedative being administered to a resident with dementia on the night before the inspection. This was recorded in the residents' nursing progress notes. It was also noted that the resident had been drowsy and quiet at times during the day. But on checking the medication administration chart it was found that the drug was not included or signed as being administered. As a means to double check whether the drug was given or not, inspectors asked to check the current stock of the drug against that recorded as being received from pharmacy. This showed that a total of 8 tablets had been removed from the stock. The drug administration records were tracked over the same period and this showed that 6 had been signed as given to the resident by the nursing staff. Two tablets could not be accounted for, due in part to the fact that the administration records were missing for a four week period.
Findings related to prescribing and administration processes also included;
- a photograph of each resident to assist in recognition during administration was not available for all residents
- maximum dosage of all pro re nata (prn) medicines was not identified
- guidance was not available to staff on the correct prn medication to administer where more than one was prescribed to treat or manage signs and symptoms of behavioural or psychological distress.

The inspectors noted that staff were trying to deliver good care to their residents. Inspectors spent time observing interactions during the early morning, prior to, during and after lunch and in the afternoon. These observations took place in communal areas on all three units in the centre.

Although several instances of person centred care were observed overall it was found that care was primarily task oriented.
Signs of restlessness, complaints of feeling cold and requests for tea were responded too by staff with reassurance. Some staff were observed to make eye contact, use touch and gentle encouragement in low key, moderate and supportive tone of voice.
When residents with limited mobility and at risk of fall were observed to attempt to stand, on two occasions staff were observed to assist them walk across the room and back to their chair which appeared to meet their need for movement. But in the majority of instances staff tried to distract, eased or simply told residents to sit back down. All communal areas in the three units were supervised and apart from short periods at least one staff member was present to ensure resident safety. Where interactions between certain residents became unfriendly, staff acted promptly to intervene, distract and separate. The staff tried to create an atmosphere of relaxation by playing background music appropriate to the age and era of residents. Several moments of spontaneity were witnessed as some of the ladies joined in, singing along to 'I did it my way' or, 'Dublin on a sunny summer's morning'. Later in the afternoon one male healthcare assistant took one of the ladies up for a little waltz in an upstairs sitting room.
But it was also observed that conversation between the staff and residents was limited to the weather, tea being on the way or who was going to Mass. Although staff seemed familiar with their basic physical care needs and some of their family background, efforts to chat to them about their family, previous interests or working life were not found. Opportunities to discover how they were feeling, what their mood was emotionally or psychologically were lost.
Staff were observed bringing residents from the communal and bedroom areas to the dining rooms for lunch. Assistance and encouragement was given to those with limited mobility to walk to help maintain functional ability.
During the lunch time period in two separate dining areas staff were observed to offer assistance in a respectful and dignified manner. All staff sat beside the resident to whom they were giving assistance and were noted to patiently and gently encourage the resident throughout their meal. Independence was promoted and residents were encouraged to eat their meal at their own pace by themselves with minimal assistance to improve and maintain their functional capacity.

Overall inspectors found there were not enough nursing staff available to direct and supervise the care that the current profile of residents needed. This is further referenced under outcome 5 staffing.

Judgment:
Non Compliant - Major

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

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

Findings:
Staff who spoke with the inspector were knowledgeable regarding what constituted abuse and how to respond to suspicions or any allegation of abuse. Measures including policies to protect residents from being harmed or suffering abuse were in place and residents spoken with confirmed they felt safe and some knew who they would speak to if they were concerned. Relatives spoken to, also stated that they felt their loved ones were safe in the centre and they trusted staff to take care of them.
Staff had received recent training in the prevention and detection of abuse and all had been through the Garda vetting process including volunteers.
The centre assisted some residents with the management of their financial affairs and on review of records and systems in place, inspectors were assured that the system was thorough and regular checks were carried out to ensure all accounts were managed transparently and securely. Two signatures were in place for every transaction and receipts available for all purchases.

There was a policy in place for behaviour that is challenging, and staff had received training on understanding and managing challenging behaviour as part of dementia care training. Inspectors observed good staff supervision of residents who exhibited challenging behaviour, and demonstrated effective interventions such as redirection and engaging with the resident. However as previously identified under Outcome 1, care plans were not in place to direct and manage the care of residents who exhibit signs of behavioural or psychological distress and appropriate interventions to improve well being were not identified.

Inspectors reviewed the use of restraint in the centre and found that there was a continued high use of bed rails throughout the centre. Evidence was found that appropriate assessments for this type of restraint were not being fully completed and there was no clear rationale for its use in many cases. This finding replicates similar findings from previous inspections in 2013.

Bed rails were in use for up to one third of residents. The rails were variously described by staff as being needed to maintain safety or for use as enablers. But risk assessments or care plans were in place, did not state how they were enabling the resident. Consultation on the decision to use the rails included residents' families in the majority of records viewed although on some only staff were involved. None viewed showed that the resident was included. Inspectors were told that a number of residents families had requested their use, but this is not in line with national policy on the use of restraint or with best practice.

Inspectors noted that there was a move towards changing the culture and promoting a restraint free environment with an increase in the use of alternative safety measures such as bed alarms, roll out mats and low low beds. Further efforts to reduce restrictive practices and put in place systems to promote a restraint-free environment were found to be needed. A policy on the use of restraint was in place in the centre, but evidence to show that all considerations were explored and found to be unsuitable before a decision was taken to use a form of physical restraint was not available in all cases. Risk assessments in place on the use of bed rail restraints were not fully completed and did not accord with national policy as published on the Department of Health website, to show that;
- the use and positioning of the rails had been assessed for risk of entrapment.
-alternative measures prior to using the restraint had been tried, for how long, how recently or with what results
-all risks involved in using the restraint had been considered
-what were the benefits, if any, of using the restraint as opposed to other measures.

Judgment:
Non Compliant - Moderate

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

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

Findings:
Some evidence that residents with dementia were consulted with and actively participated in the organisation of the centre was found. Overall residents' rights, privacy and dignity was respected with personal care delivered in their own bedroom or in bathrooms with privacy locks and the right to receive visitors in private. There were no restrictions to visiting in the centre and many residents were observed spending time with family or friends, reading newspapers books or chatting in the large open plan foyer which was bright and spacious with soft comfortable furnishings and a coffee dock which provides drinks and snacks.
Inspectors were told that residents were enabled to vote in national referenda and elections with the centre registered to enable polling.
Choice was respected and residents were asked if they wished to attend Mass or exercise programmes. Control over their daily life was also facilitated in terms of times of rising /returning to bed and whether they wished to stay in their room or spend time with others in the communal rooms. Staff were observed to interact with residents in a warm and personal manner, using touch, eye contact and calm reassuring tones of voice to engage with those who became anxious restless or agitated.
Staff were observed to patiently assist residents with their lunch meal to enable conversation and promote independence as previously referenced under outcome 1. But

there were occasions where staff did not provide assistance in a dignified manner and were observed standing over residents when assisting with drinks in communal sitting room areas.

Evidence that residents were involved and included in decisions about the life of the centre was viewed. A monthly meeting was held where residents were consulted about future activities or outings. As a result of the most recent meeting plans were being made to bring a group to the cinema. Photographs of a recent outing to Dollymount strand were being shown to one resident.
However, residents with dementia did not have access to an independent advocacy service. It was noted that this had been discussed with residents at a recent meeting in May last. At that time it was agreed to seek the services of the SAGE advocacy group, but a follow up to action this was not documented. In conversation with the person in charge, inspectors were told that due to demand there was a delay in accessing this service currently.

In conversation with activities coordinators', nurses and healthcare staff, inspectors learned there was a varied activities programme with arts and crafts, exercise and drama included.
Residents life stories, 'all about me' were collated by the activity staff who kept this information. But there was little evidence that any of these life stories which included information on personal preferences and past interests and working lives of residents informed any of the activity programmes being delivered. The activities staff deliver the programme mostly in group sessions. One to one interactions were limited to 'chats'. But although inspectors observed all staff chatting with residents throughout the day, conversations were limited to the weather, enquiries on whether they enjoyed their tea, or slept well. It was noted that although staff knew and called residents by their name , no staff member introduced themselves to the resident and no resident was asked what form were they in, how their family were, or if there was anything they would like to do, or engage in conversation on their past lives or interests.
It was found that although care staff were familiar with their residents, this seemed limited to recognition of close family, knowledge of physical needs and behavioural signs and symptoms. This appeared due in part to a very clear separation of staff roles and responsibilities and lack of crossover or communication between all staff grades. It was found that communication and information provided to healthcare assistants consisted primarily of a daily verbal report provided by the nursing team each morning and instructions on changes given throughout the day by the nursing staff or senior healthcare assistant.
In conversations with them, the care staff stated they did not have opportunities and were not encouraged to read residents' files and did not have access to their life stories.
In conversation with some residents and relatives, they expressed satisfaction with the level activities on offer.
But it was noted that the activity programme did not include any dementia specific or orientated activities such as Sonas, massage, meditation or other sensory therapeutic sessions for those residents with advanced dementia and/or limited physical abilities.

Judgment:
Non Compliant - Moderate

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:
A complaints process was in place to ensure the complaints of residents, their families or next of kin including those with dementia, were listened to and acted upon. The process included an appeals procedure.

The complaints policy which was displayed met the regulatory requirements. Some residents and those relatives spoken to could tell inspectors who they would bring a complaint to. Records showed that complaints made to date were dealt with promptly and the outcome and satisfaction of the complainant was recorded.

Judgment:
Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Recruitment processes were reviewed on this inspection and on review of a sample of staff files these were found to meet the requirements of Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009. This included Garda vetting processes which were also in place for volunteers working in the centre.
Mandatory training was in place and staff had received up to date training in fire safety, moving and handling and safeguarding vulnerable persons.
In conversation with them and on observing practice staff were found to be knowledgeable in these areas and implemented the principles of training provided. The person in charge had a training plan in place for 2015 and staff were also provided with recent training in person centred dementia care. A total of 5 sessions were delivered and inspectors were told the majority of staff had now attended this training. Other training

included MUST nutritional scoring; medication management via HSEland and external pharmacist and infection control.

It was found that at the time of this inspection, the levels and skill mix of staff were not sufficient to meet the needs of residents. Specifically this related to a lack of appropriately qualified nursing staff, although, inspectors were told and it was observed that healthcare staff were very busy and often times stretched to meet residents needs in a timely manner.
This was a recurrent finding on previous inspections and reflects information received in recent months by the Authority in the form of concerns from relatives of current residents.
As previously referenced under Outcome 1 a good standard of safe and suitable care was not found to be delivered to residents.

The inspection team found that the current profile of residents in the centre were frail and elderly with a high level of complex needs. The age profile included four residents between the ages of 98 and 102 and in total 42% were between the ages of 85 and 95. It was also noted that 57% of all residents were assessed as being at maximum dependency, meaning that they required the assistance of two staff with most or all of the activities of daily living.
As previously stated 55% had a diagnosis of dementia and 65% had an impaired cognitive ability. Additionally approximately 60% were assessed as being at risk of falls, yet it was found that only one nurse was rostered on each unit for between 27 to 31 residents over a twenty four hour period. This lack of skilled nursing personnel was found to directly and negatively impact on residents.
Examples include;
- care plans not in place for every identified need and where they were in place were not fully implemented; care plans not being reviewed on a quarterly basis or as needs or circumstances changed. When reviews did take place they did not assess the effectiveness of the plan to establish sufficiency to maintain or improve health.
- residents nutritional intake not being adequately monitored and recommended interventions by dietetic specialists not being implemented to prevent or reduce risk of malnutrition. Nursing staff were not aware of all residents with recent significant weight loss and appropriate interventions to address this were not in place.
- falls risk assessments not being updated and care plans not detailed enough to direct care. Four falls between May and July 2015 resulted in significant injuries to residents with three sustaining fractured hips and one sustaining a fractured ankle.
- lack of suitable supervision of care practices to ensure care was delivered by healthcare staff in line with best practice, training and recommendations of allied health professionals. Examples included residents not being repositioned on a strict two or three hourly basis and preventative measures such as cushions or heel protectors not in place.
- documentation of care delivered was not sufficiently complete to enable an overall picture of residents current health condition be determined. Although some residents were identified as having skin tears or being at high risk of developing pressure ulcers daily monitoring of whether residents' skin was intact or not was not always found. On a sample of 28 flow charts viewed only 8 indicated whether skin was intact. Nurses daily progress notes was mainly summation and did not give a clear picture of residents' current health in that mood, participation in activities, interaction with staff family or

other residents was not detailed. Where residents were noted to be drowsy or confused during the day, interventions made such as type of/ or increases in supervision, medication monitoring and/or review of use of sedation was not always identified.
- Although it was noted that nursing staff were familiar with the residents on their respective units they did not have in depth knowledge of all of their care needs, past history or current condition. Inspectors found that this was due to the inability of one person to provide safe levels of nursing care to 29 or 31 frail elderly persons with very complex needs. Also this was due in part to a recent high turnover of staff with new nursing personnel only recently recruited, some completing induction and use of agency staff.

On one unit there was an additional nurse on duty who was completing an induction process and was awaiting their registration personal identification number with the Irish Nursing Board.
The other staff nurse on duty was endeavouring to assist this new nurse become familiar with the layout and policies/ processes in place whilst also carrying out all of their own nursing duties.
It is accepted however, that the induction of the new nurse may ordinarily have been conducted by the clinical nurse manager who was facilitating the inspectors throughout the day.
On another unit the nurse on duty had only recently completed their induction some weeks earlier and was just beginning to become familiar with residents.
Inspectors learned that in recent months due to the high turnover there had been a heavy reliance on agency nursing staff particularly through the summer period, where up to three agency would have been required in any one week, although this had now eased.

- Issues relating to the size and layout of the centre also posed considerable problems for staff in meeting residents' needs given the current level of staff.
The centre is spread across two floors where residents reside. The centre was extended in 2012 to increase capacity. Each unit is made up of two corridors. Inspectors found staff have to travel considerable distances from one corridor to another in order to deliver care.
Inspectors found that call bells continuously rang particularly in the afternoons and late evening when many residents who may have been up in the communal areas returned to bed early or returned to their rooms to rest. Inspectors noted several occasions over both days of inspection when call bells were ringing for up to and over five minutes whilst residents sought help. These were particular pressure points for staff due to the return of residents to their rooms coinciding with staff going on their meal breaks.
-the layout of the centre in terms of geographical spread is such that on the first floor from one end of a unit to the other, which encompasses the two corridors, measured approximately 120 metres, during the day there are 5 care assistants and one nurse and at night there is one care assistant and one nurse with one 'shared' care assistant between two units on the first floor. The ground floor was similarly long.
- Staffing numbers and skill mix on each unit were similar with one nurse on duty over twenty four hours delivering direct care. Six care assistants were on duty each morning up to 13:30 decreasing to five until 20:00 and then reducing to three until 22:00 when it reduces to one with one shared between the two units on the first floor. In response to relatives concerns the provider had increased the number of care assistants at 'peak'

times by introducing two additional shifts. One shift early in the morning from 08:00-12:00midday and a late evening shift from 16:30 -22:00 daily. But these extra staff were only placed on one specific unit and not across all three units. The provider advised the Authority that direct care hours within the centre had been increased over recent years and were in line and in one unit, exceeded recommended care hours, using recognised staffing review tools. But inspectors noted that the skill mix did not reflect recommended ratios and were in fact at the very minimum of 1 nurse providing direct care to 29 residents across the centre.
The number of nursing staff on duty providing direct care to residents was not sufficient to ensure a safe standard of care was delivered.
Due to the findings the inspector informed the provider nominee and the person in charge that, at a minimum, additional nursing staff of one nurse per unit over the twelve hours day shift were immediately required to improve the standard of care. A written assurance was given to the inspector that this would be implemented from the day following the inspection.

Judgment:
Non Compliant - Major

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Nazareth House is a purpose-built residential care facility for older people. The centre commenced operation in 1970. It is set on a large site with ample car parking to the front and manicured lawns accessible to residents at the side and rear of the building. Originally built to accommodate 73 residents, the centre was extended during 2012 and an application to vary registration conditions to increase resident numbers to 87 was granted in January 2013

A new extension was built over three floors, ground, first and second level. Residents of the centre only reside on the ground and first floors.
The new extension included a large sunny foyer on the ground floor with comfortable seating, coffee dock, residents shop and access to an enclosed accessible garden with walkways and seated areas.
The first floor extension comprised of 15 bedrooms with full en suite, a computer room, sluice, nurses' station, medical storage rooms and assisted bathroom and is accessed by both stairs and lift from the ground floor.

However, during the registration inspection the physical environment of the original

building was found to pose challenges to meet residents' needs safely and improvements to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland improvements were required by 2015.
Findings on this inspection replicated the findings of the registration inspection in 2013 in that, aspects of the design and layout of the centre was not suitable for its stated purpose and did not meet residents needs in a safe and comfortable way.
In summary the main environmental challenges relate to;
-design and layout of the bedrooms with shared 'en suite facilities' do not meet residents' needs for privacy, dignity and access to appropriate toilet or washing facilities. They did not allow safe access to residents using assistive moving and handling equipment or allow staff to provide safe assistance to residents with low dependency needs.
- 13 bedrooms did not meet the requirements of the legislation in terms of usable space for residents.
- insufficient number of appropriately located wheelchair accessible toilets and shower/bath facilities in the centre.
- insufficient number and inappropriate location of sluice facilities.
- ramped areas of the internal centre were steep and posed problems for both staff and residents in terms of access and safety.

The provider informed the Authority in 2013 that as part of the action plan response to the registration report that plans for a new development including the construction of a new building were being drafted and would be commenced to ensure compliance with the relevant regulations and standards by July 2015.
Inspectors were told that difficulties with the planning process and changes to the design of the new build had resulted in lengthy delays to the commencement of the building. But Inspectors were given evidence of confirmed planning permission and copies of draft architectural design plans by the provider prior to the end of the inspection.
The provider was hopeful that the finalised architectural design plans would be ready in the coming weeks and a revised timeframe for the commencement and completion of works. The revised timeframes are now;
Preparation works; October- November 2015
Commencement of construction; November 2015- October 2016

The premises were noted to be maintained to a good standard and evidence of ongoing maintenance, such as painting and repairs to the fabric of the building was found. In general the building was found to be clean and walkways were free of clutter, although a number of areas required improvement, to ensure a good standard of cleanliness throughout the day.
It was noted that there were a team of nine household staff working throughout the centre from 08:00 – 14:00 approximately. But there were no household staff on duty after this time. Inspectors observed several areas that needed cleaning in the late afternoon and evenings including, residents' toilets where floors were noted to be very wet around toilet bowls and on the toilet seats and there was a very strong smell of urine, sluice rooms with overflowing waste bags and bags leaking onto equipment stored in the room such as commode chairs.

Signage and cueing within the centre needed to improve to support freedom of movement for residents with dementia. Picture and colour cueing was not found and the function of all rooms within the centre was not identified.

Judgment:
Non Compliant - Major

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:

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Regulation Directorate
Health Information and Quality Authority

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Regulation Directorate

Action Plan

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

Provider's response to inspection report[1]

Centre name:	Nazareth House
Centre ID:	OSV-0000149
Date of inspection:	25/08/2015
Date of response:	09/10/2015

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 Registered Provider is failing to comply with a regulatory requirement in the following respect:
All the care needs of all residents were not being met and suitable safe and sufficient care was not being provided.

1. Action Required:
Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

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

Please state the actions you have taken or are planning to take:
The PIC and RP are committed to ensuring that the care and welfare needs of residents are met to a high standard in accordance with Regulation 05 (1) & (2). In doing so, the PIC currently collects data on areas identified under Standard 30. Moving forward, the data collected from these will be used to make improvements and take corrective action where required.

There will be a more structured and formalised auditing programme which will allow for a systematic review of the organisation. This will involve comparing current practice to evidenced based best practice (HIQA Standards and SI 415). This will provide the RP & PIC with the information needed to identify areas for quality improvement and where necessary implement changes to practice to demonstrate effective compliance.

The RP is committed to focusing, over the next three months, on the nursing process, pressure area care, nutrition and dementia care.

The RP & PIC have identified a need for a more robust clinical risk register which they will develop, implement and use as a tool to improve clinical risk management. As a strategy to improve the overall governance and practices within the centre the RP & PIC will meet formally on a fortnightly basis to hold a governance meeting. The agenda items will include clinical risks, workforce issues, communication, health & safety management.
The RP, PIC & CNMs will all have on-site practical audit training.
First governance meeting – Monday 13th September 2015. Completed.
Clinical risk register – Completed.
Quality Monitoring system (as per Standard 30.2):
Documentation to be amended - Completed
Monitoring system to be implemented in practice 28th October 2015.
Audit programme plan for the next twelve months – Complete.
Audit training – Completed.

Proposed Timescale: 28/10/2015

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Assessment, care planning and clinical care did not accord with current evidence-based practice.
Complete comprehensive nursing assessments were not carried out for each resident in respect of every identified need.

2. Action Required:
Under Regulation 05(2) you are required to: 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 the designated centre.

Please state the actions you have taken or are planning to take:
The PIC does undertake a comprehensive pre-admission assessment which does form the basis of the care plan which is always commenced within 48 hours of admission and this practice will continue.

As described in the action response above, under Regulation 05(1), the quality monitoring and auditing programme will be implemented and appropriate actions taken where necessary.

All nursing staff will attend training on care planning which will include use of a nursing model, implementing the model in practice, using the nursing process and in particular assessing residents to ensure that all care needs are correctly identified and addressed in the care plan. There will also be a focus on ensuring that clinical risk assessments and tools used are understood in terms of their relevance for each individual resident and ensuring that there is a tangible link between risk, risk assessments, care planning and practice.

The care plan training will comprise of a formal teaching session with all nurses, followed by practical guidance. The training will include, where evidence based practice can be sourced, how to identify care needs, documenting care needs, identifying goals and aims of care, planning care, evaluating care and ensuring that the documentation is reflective of a person centred approach.
Planned audit of care plans will form an intrinsic part of the audit programme which will be implemented fully over the coming months. The care staff will have training on their roles and responsibilities also to ensure the documentation that they are responsible for and involved in is maintained, accurate, reflective of the care given and contemporaneous.

Once the training is complete, all care plans will be reviewed and updated to ensure they are person centred, comprehensive, reflective of the residents' current status, correctly identify residents' care needs and to ensure that the actions identified in the care plans are in line with best practice guidelines.

The PIC will ensure (through regular audit) that the resident assessments clearly identify all residents' care needs.

Care plan training – Completed.
Review and update all care plans – to be completed by the end of December 2015

Proposed Timescale: 31/12/2015

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Assessment and care planning were not specific enough to direct the care to be delivered in an holistic manner as evidenced by examples such as residents experiencing falls, exhibiting behavioural signs of distress, significant weight loss and

the clinical deterioration of pressure ulcers.

3. Action Required:
Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

Please state the actions you have taken or are planning to take:
The care plan is commenced within 48 hours of admission.

As described under Regulation 05(2) above, all nursing staff will attend care planning/nursing process training. The care plans will be updated and amended to guarantee that they are specific enough to direct the care to be delivered and to ensure that they direct holistic and person centred care. This in itself is a significant undertaking and one we are fully committed to, which is reflected in the proposed timescales.

There will be planned audits of care plans to ensure that assessments and care planning are specific enough to direct care in a holistic manner.

Prior to the commencement of the training there will be a full care plan audit (already underway) to identify the specific areas that need to be addressed and once the care plans have been updated and amended there will be a follow up audit to review progress and identify any further training needs.

Proposed Timescale:
Care plan documentation audit - Completed.
Care plan training – Completed.
Care plan reviews, updates and amendments – end of December 2015.
Care plan repeat audit – January 2016.

Proposed Timescale: 31/01/2016

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Evidence that all care plans were fully reviewed for effectiveness as residents needs changed and records of residents current overall condition as required by the regulations were not available

4. Action Required:
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

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

The Person in Charge will ensure that all care plans are reviewed formally on a four monthly basis at a minimum and where a change in the residents' status indicates the need for review. As described under Regulation 05(3) above regular audit of the care plans will allow the PIC to ensure that the care plans correctly reflect the status and needs of the residents and to know that the actions identified will be effective to meet the needs of residents.
Care plan audit – as above
Four monthly review -ongoing

Proposed Timescale: 31/01/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The documentation of care was not sufficiently accurate or complete to determine that a high standard of evidence based nursing care was being delivered to all residents to fully meet their personal social and healthcare care needs.

5. Action Required:
Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

Please state the actions you have taken or are planning to take:
The RP & PIC will ensure that all documentation used to show care is delivered, is completed and accurate and will also ensure that the records are contemporaneous and provide evidence to demonstrate that the care delivered is both evidence based and fully meets the care needs of residents. All documentation is currently being reviewed, updated and amended as necessary. Once this is complete, staff will be instructed on its use and the CNMs will take a more active role in ensuring that they are properly completed.

The RP in liaison with the PIC will also arrange for all direct care staff to attend pressure area prevention and care training which will include the need for accurate documentation. The pressure area care policy is currently being reviewed and will form a part of this training.

The PIC, CNMs and staff involved in auditing will have external support in developing their auditing skills.
Pressure area care training – Completed.

Proposed Timescale: 09/10/2015

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The nutritional needs of all residents were not being met and some had experienced significant weight loss.
Specialised diets and food fortification as prescribed by specialist staff were not being followed or included in updated care plans based on nutritional assessments.

6. Action Required:
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:
In order to address the issues identified in the report, the centre will establish a nutrition committee with members of each relevant department participating and this will be chaired by a CNM to be appointed as lead nurse for nutrition. The dietitian, who visits the centre on a six /eight weekly basis, will also attend this meeting. The Person in Charge will ensure that the overall monitoring system will include weekly/fortnightly weights as well as nutrition monitoring for those residents determined to be at high risk and will ensure that when a need is identified diet and fluid intake charts will be maintained. All other residents will be weighed monthly as is currently the practice.

The Lead Nurse will take an active role in ensuring that the prescribed specialised diets and food fortifications are updated and included in the care plans and will ensure that staff are knowledgeable about these. On the 28th of August the dietitian commenced documenting on the live computer system, her recommendations for specialised diets and food fortification.

Planned nutrition audit will be a part of the audit programme.
Lead Nurse identified – Complete.
Nutrition Committee establishment – By 19th October2015.

Proposed Timescale: 19/10/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Records of the food provided to residents were not maintained to enable a determination be made on the adequacy of the diet being provided as required under Schedule 4(5)
All medication administration records were not available as required by Schedule 3 (4)(d)

7. 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:
The records were filed in the filing cabinet but were not in the correct lever arch file and have since been submitted to the Authority.

The Registered Provider and Person in Charge have met with the dietician who agrees that three day food diaries have always been maintained when requested. In order to address the issues identified in the report, the centre will establish a nutrition committee which will have members of each relevant department and will be Chaired by a CNM to be appointed as lead nurse for nutrition. The dietician, who visits the centre on a six/eight weekly basis will attend this meeting. The Person in Charge will ensure that as part of the overall monitoring system to be implemented that nutrition including resident weights are monitored on a weekly/fortnightly/monthly basis (as described above) and will ensure that when a need is identified diet and fluid intake charts will be maintained.

Moving forward; (i) regular nutrition audits which include methodologies such as documentation review, observation and discussion with staff will form part of the centre's audit programme and; (ii) records of food provided will be maintained, where there is a need identified.
Documentation amendment - Complete.
Weekly/fortnightly monitoring – by 19th October 2015.
Nutrition Committee – 19th October 2015.

Proposed Timescale: 19/10/2015

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Medication records were not maintained in full accordance with all current legislation and professional guidance in that;
a photograph of each resident to assist in recognition during administration was not available for all residents
- maximum dosage of all pro re nata (prn) medicines was not identified
- guidance was not available to staff on the correct prn medication to administer where more than one were prescribed to treat or manage signs and symptoms of behavioural or psychological distress.

8. Action Required:
Under Regulation 29(2) you are required to: Facilitate the pharmacist concerned in meeting his or her obligations to a resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland.

Please state the actions you have taken or are planning to take:
1.All medication charts will be checked to ensure that there is a photograph of each resident to assist with recognition during administration.
2.The need for maximum dosage of all pro re nata (prn) medicines has been discussed

with the medical practitioners who have accordingly agreed to document this. They have also agreed that guidance will be made available to staff on the correct prn medication to administer where more than one has been prescribed.
3.In future, to ensure safe medication practices are adhered to, there will be a monthly medication chart audit, weekly monitoring of the use of anxiolytics, psychotropic, anti-depressants and sedatives (to include a review of the occasions and rationale for the use of these medications especially on a prn basis). A more detailed audit of medication practices will also form part of the annual audit programme for the centre.
4.As a means of ensuring safe practices the PIC will ensure that all nurses have medication competency assessments done on at least an annual basis and following any medication incident reports as well as part of a newly inducted nurse recruitment programme Currently all nurses have completed HSELand medication management programme. This will be updated annually.
5.Following a full medication management audit, any training needs identified will be addressed accordingly. The Pharmacist already provides on-site training.
6.The findings of the report with regards to medication will be discussed with nursing staff at the handovers and the next nurses meeting.
1.Completed.
2.Ongoing and current medication charts to be reviewed by GP's – Completed.
3.Ongoing.
4.As part of the planned audit programme.
5.Ongoing.
6.Completed.

Proposed Timescale: 09/10/2015

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Evidence to show that all considerations were explored, in line with national policy as published on the Department of Health website, and found to be unsuitable before a decision was taken to use a form of physical restraint was not available.

9. Action Required:
Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

Please state the actions you have taken or are planning to take:
The restraint policy was reviewed in March 2015 and is reflective of the national guidelines towards a restraint free environment.

A full audit will be undertaken to determine the number of restraints (bedrails) in use and the use of risk assessments, consent etc. The audit will be used to determine staffs level of understanding of both what restraint is and best practice in this area. Once this

is complete, the Registered Provider will ensure that all staff have further instruction on the implementation of the policy, the use of restraint devices and the correct procedures and systems to employ when considering the use of any device which is restrictive.

The current document used for assessing the need for restraint will be reviewed and consideration will be given to risk such as entrapment and choking. In the future, regular audit of the use of restraint (physical and chemical) and restrictive devices will form part of the annual audit and monitoring programme for the centre.
Staff instruction training - Completed.
Documentation review - Completed.
Audit to be complete by end of October 2015.

Proposed Timescale: 31/10/2015

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Independent advocacy services were not available to residents including residents with dementia.

10. Action Required:
Under Regulation 09(3)(f) you are required to: Ensure that each resident has access to independent advocacy services.

Please state the actions you have taken or are planning to take:
In keeping with SI 415, 09(3)(f): the Registered Provider is committed, insofar as reasonably practical, to providing independent advocacy services. To date, the RP has contacted SAGE and is currently waiting for an advocate to be appointed. The Registered Provider has engaged for the last twelve months the services of two members of the Sisters of Nazareth (who are not employed by the centre) to provide advocacy services to residents. They attend the Residents' Committee meeting and represent all residents, including those with dementia and cognitive impairment.

The Registered Provider will continue to engage with SAGE and will, as soon as an advocate is appointed, notify residents and amend the Residents Guide accordingly.
Ongoing

Proposed Timescale: 30/11/2015

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Purposeful or meaningful activities were not provided for those residents with advanced dementia and/or limited physical abilities.
Activities which reflected residents life stories or male orientated activities for the male resident population were not included or evident on the activities programme or referenced in group or one to one sessions.

11. 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 Registered Provider will review the current activities programme which does include Sonas, reminiscence and purposeful activity. In undertaking the review the Provider will ensure that the activities which are taking place are correctly documented on the activity programme and will continue to ensure that the programme is implemented. We have previously discussed with male residents, what, if any, activities, they would like to see in the programme, and as shown, the Men's' Shed was not successful. We will continue however to encourage them to request activities that they would have a preference for. Currently, there are many of the male residents who attend and enjoy, keep fit, arts & crafts, physio, drama etc. There is also a therapeutic/tranquillity room, which is used by both female and male residents. The male residents do enjoy outdoor activities and enjoy trips outside the centre.

We will also audit activity programmes for the last three months to establish attendees and participations.
Activity programme review - Completed.
Activity audit – Completed.
Committee meeting - ongoing.

Proposed Timescale: 09/10/2015

Outcome 05: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The number and skill mix of staff was not sufficient to meet the assessed needs of residents and did not take account of the size and layout of the centre.

12. Action Required:
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
Having reviewed the Inspectors findings and the content of the report, we accept that a workforce/staffing review was necessary. Part of our review was a consideration of why

non-compliances may occur and we recognise that there is a need to improve supervision. Our plan is to divide our nursing home into three single units. Each unit will be overseen by a full-time CNM who will support the staff nurse with direct care and provide a continuous supervisory system (there are currently two CNMs, the plan is to increase this to four). This in turn will ensure that there are two qualified nurses per unit, five days per week. We will also be ensuring that there is a CNM on duty to provide senior nurse cover out of hours up to 20.00 and at weekends.

We will also recruit a full-time Assistant Director of Nursing. The purpose of this position and its main focus will be on clinical care governance and ensuring that the care delivered is of a high standard and in addition that documentation is maintained in accordance with the regulatory requirements.

In the interim period, while recruiting for the above positions, we have (agency and recruitment processes permitting) rostered six nurses on duty 0800-2000 each day.
Recruitment of ADON – Completed. Person to commence on October 10th.
Recruitment of CNMs – Process has commenced. One part time CNM to commence on October 24th. Recruitment for other position ongoing.

Proposed Timescale: 30/10/2015

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The number of nursing staff on duty providing direct care to residents were not sufficient to ensure a safe standard of care was delivered.

13. Action Required:
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
The RP will ensure that the number of nursing staff on duty providing direct care is sufficient enough to ensure that a safe standard of care is provided. Following an initial review of the centres, documentation and care records, we have identified there is a need for improved supervision and guidance for nursing and care staff. As described in the action above we have put in place a plan which will address the concerns identified.
Ongoing

Proposed Timescale: 30/10/2015

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Staff were not appropriately supervised to ensure that a good standard of care was delivered which met residents needs in accordance with their care plan.

14. 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:
The PIC will ensure that staff are appropriately supervised and in order to meet the requirement, the RP has increased the number of CNM posts from two to four and will be appointing an ADON.
Recruitment process has begun. The Authority will be further notified as the appointments are made.

Proposed Timescale: 30/10/2015

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The design and layout of the centre is not currently suitable for the purpose of achieving the aims and objectives set out in the statement of purpose.

Services and facilities available do not meet the assessed needs of all of the current resident profile.

15. 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:
While the Provider is very much aware, that, not all of the design and layout of the centre currently meets the requirements of Standard 25, Regulation 17.1, the Provider is committed to rectifying these issues, and, as reported, has approved an expansion plan which is due to commence on 10th November 2015 with an anticipated completion date of 1st November 2016 (phase 1). Within this expansion plan, all the areas of concern are addressed. Copies of same have been provided to the Authority.

Proposed Timescale: 24/11/2015

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The centre currently does not meet the requirements of Regulation 17 or Standard 25 (Physical Environment) of the National Quality Standards for Residential Care Settings for Older People in that; the physical design and layout of the premises does not meet the full needs of the current resident profile and all aspects of the premises are not accessible, hygienic, spacious or well maintained. The premises do not fully conform with all requirements of schedule 6 of the regulations

16. Action Required:
Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

Please state the actions you have taken or are planning to take:
While the Provider is very much aware, that, not all of the design and layout of the centre currently meets the requirements of Standard 25, Regulation 17.1, the Provider is committed to rectifying these issues, and, as reported, has approved an expansion plan which is due to commence on 10th November 2015 with an anticipated completion date of 1st November 2016 (phase 1). Within this expansion plan, all the areas of concern are addressed. Copies of same have been provided to the Authority.

The centre does employ two full-time maintenance personnel who are actively involved in the day to day maintenance of the centre. To ensure that where possible that the centre does meet the requirements the RP and Maintenance Manager will carry out a planned walkthrough of the building to identify areas where maintenance is required and will address all non-structural tasks, including painting and new flooring, while we wait to begin the works above.
Start date 24th November 2015 and completion 9th December 2016 (phase 1).
Walkthrough – Completed. Painting _ October 13th. Flooring –October 28th.

Proposed Timescale: 09/12/2016