# Health Information and Quality Authority

## Regulation Directorate

## Compliance Monitoring Inspection report

Designated Centres under Health Act 2007, as amended

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Nazareth House Nursing Home Sligo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000369</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Church Hill, Sligo Town, Sligo.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>071 918 0900</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:catherinenaz@eircom.net">catherinenaz@eircom.net</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
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<tr>
<td>Registered provider:</td>
<td>Nazareth House Management Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Cora McHale</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Marie Matthews</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Mary McCann</td>
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<tr>
<td>Type of inspection</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>60</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>10</td>
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About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider’s compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

▪ to monitor compliance with regulations and standards
▪ to carry out thematic inspections in respect of specific outcomes
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.
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 inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times
From: 22 June 2016 09:00  To: 22 June 2016 20:30
23 June 2016 09:00  23 June 2016 20:00

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

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<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
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<tr>
<td>Outcome 01: Statement of Purpose</td>
<td>Compliant</td>
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<tr>
<td>Outcome 02: Governance and Management</td>
<td>Non Compliant - Moderate</td>
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<td>Outcome 03: Information for residents</td>
<td>Non Compliant - Moderate</td>
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<td>Outcome 04: Suitable Person in Charge</td>
<td>Compliant</td>
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<td>Outcome 05: Documentation to be kept at a designated centre</td>
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<td>Outcome 06: Absence of the Person in charge</td>
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<td>Outcome 07: Safeguarding and Safety</td>
<td>Substantially Compliant</td>
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<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 09: Medication Management</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 10: Notification of Incidents</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
<td>Substantially Compliant</td>
</tr>
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<td>Outcome 13: Complaints procedures</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 14: End of Life Care</td>
<td>Compliant</td>
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<td>Outcome 15: Food and Nutrition</td>
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<tr>
<td>Outcome 16: Residents' Rights, Dignity and Consultation</td>
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<td>Outcome 17: Residents' clothing and personal property and possessions</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Non Compliant - Major</td>
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Summary of findings from this inspection
This report set out the findings of an announced registration renewal inspection, which took place following an application to the Health Information and Quality Authority (HIQA), to renew registration of the designated centre.
The centre can accommodate a maximum of 70 residents who need long-term care, or who have respite, convalescent or palliative care needs. There were ten vacancies
at the time of inspection. Inspectors reviewed progress on the action plan from the previous inspection carried out 1 April 2015.

There were substantial changes to the governance structure since the last inspection. A new board of management was in place and a new provider nominee was appointed. The previous person in charge had been on secondment from the Health Services Executive (HSE) and had returned to her substantive post. A new person in charge had also just taken up post and a clinical nurse manager had been recruited but had not yet started. Inspectors met with the new person in charge and ascertained that she was suitably qualified and knowledgeable of the regulatory responsibilities of the post. An ex Director of Nursing DON had been recruited to support the new person in charge and assist with the clinical governance.

A number of questionnaires from residents and relatives were received prior to the inspection and Inspectors spoke to residents during the inspection. The feedback from residents was in the main positive but feedback from some relatives and from the questionnaires was mixed. Inspectors identified that some care was not evidence-based and this was relayed to the person in charge and deputy DON at the end of the first day of inspection who took immediate action to mitigate the risks identified. Inspectors also identified that the deployment of staff was not ensuring that residents had appropriate supervision. The range of activities available was limited however; an activities coordinator had been recruited to help improve this area. Inspectors identified non compliances in ten of the eighteen outcomes reviewed.

Areas of concern were highlighted by inspectors and the CEO, person in charge and deputy DON outlined their plans to address these. Included in these are plans was the recruitment of additional staff, the appointment of a new Clinical Nurse Manager, supervision of all wound care plans by a specialist and a review of staffing levels. The provider has also been requested to submit weekly reports to HIQA on residents with pressure wounds. The action plan at the end of this report identifies these and other areas where improvements must be made to meet the requirements of 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.
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: Statement of Purpose
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Governance, Leadership and Management

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

Findings:
The Statement of Purpose set out the services and facilities provided in the designated centre and contained all the requirements of Schedule 1 of the regulations. The Statement of Purpose was kept up to date and had been revised in June 2016.

 Judgment:
Compliant

Outcome 02: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management

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

Findings:
There were changes to the governance structure since the last inspection. A new board of management was in place and a new provider nominee was appointed. The person in charge who was on secondment from the Health Services Executive (HSE) and had returned to her substantive post and a new person in charge had been appointed and a clinical nurse manager had been recruited but had not yet taken up the position. A retired director of nursing had returned to the centre to oversee clinical care and to ensure a safe, appropriate and consistent service in the interim period.
Governance arrangements were in place which included regular scheduled meetings between the provider and the person in charge and between the person in charge and staff members. The provider nominee was on planned leave on the day of inspection and will be interviewed in relation to the governance of the centre on her return. The CEO of Nazareth Care attended the feedback meeting at the end of the inspection and gave a commitment to ensuring that effective management systems and sufficient resources were in place to ensure the delivery of safe, quality care services.

An audit program was in place and inspectors saw that a schedule of audits was planned to ensure clinical indicators were regularly reviewed. However inspectors identified a range of issues with care plans which had not been identified or addressed as a result of the audits completed. A quality improvement was completed by the previous person in charge based on audits completed during 2014, however the audits completed during 2015 had not yet been collated or a quality improvement plan developed in consultation with the residents.

**Judgment:**
Non Compliant - Moderate

### Outcome 03: Information for residents

*A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.*

**Theme:**
Governance, Leadership and Management

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

**Findings:**
Inspectors found that each resident had a written contract agreed. The contract included details of the services to be provided and the fees payable by the residents. A sample of contracts was reviewed and all contracts were signed by the resident or their next of kin and specified the amount paid by the Fair Deal Support Scheme. The amount contributed by a resident from their pension was clear but additional cost not covered by the overall fee which might be incurred by residents for example, chiropody, hairdressing and escort to appointments were not clearly explained or appended to the contract of care.

There was a residents’ guide available containing information required by the regulations. This detailed the visiting arrangements, the term and conditions of occupancy, and the services provided however the complaints procedure was not clearly summarised in the guide in a manner which allowed the resident to clearly understand the procedure.

**Judgment:**
Non Compliant - Moderate
**Outcome 04: Suitable Person in Charge**
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The newly appointed person in charge fulfils the criteria required by the regulations in terms of qualifications and experience. She is a registered nurse and holds a full-time post. She maintained her professional development and completed various courses since qualifying as a nurse including a certificate in gerontology, a diploma in palliative care.

She was only in post for a week at the time of inspection so had not had the opportunity to become fully familiar with the residents care needs. However, she could describe in an informed way how residents care needs would be met from the preadmission assessment prior to admission to end of life care planning. She has dedicated time allocated to manage the clinical governance and administration duties required by the post of person in charge however at the time of the inspection she was working on the floor to familiarise herself with residents and with staff.

**Judgment:**
Compliant

**Outcome 05: Documentation to be kept at a designated centre**
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

**Theme:**
Governance, Leadership and Management

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

**Findings:**
Inspectors found that there were systems in place to maintain complete and accurate records. Records were stored securely and easily retrievable. Written operational policies were available to guide practice, however some required review to reflect national
policy. The directory of residents contained all the information required by schedule three of the regulations and was maintained up to date.

Care and medical records and other records, relating to residents and staff, were maintained however on review some inspectors found that some care records were poorly completed and some care plans lacked sufficient detail to guide care. Staff files reviewed were found to contain all of the information required in the regulations and information was organised so it could be easily retrieved.

**Judgment:**
Non Compliant - Moderate

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**Outcome 06: Absence of the Person in charge**

The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The provider was aware of the requirement to notify the Chief Inspector of the proposed absence of the person in charge for a continuous period of 28 days.

The acting deputy director of nursing was identified as the person who would deputise in the absence of the person in charge. Once the new clinical nurse manager is appointed and completed a period of induction, this role will be fulfilled by them.

**Judgment:**
Compliant

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**Outcome 07: Safeguarding and Safety**

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

**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 safeguarding policy and procedures available. The policy required review to reflect national policy and procedures as outlined in 'Safeguarding Vulnerable Persons at Risk of Abuse' (HSE 2014).

All staff spoken with were able to explain the different types of abuse, signs to look out for and knew the procedure to report any suspicious of abuse. This was an action from the previous inspection. Staff identified the person in charge as the person to whom they would report a suspected concern and were aware of the role of the Health Service Executive (HSE) adult protection case worker. Inspectors viewed records confirming there was an ongoing program of refresher training in protection of vulnerable adults. One notifiable adult protection incidents had occurred since the last inspection and this had been appropriately investigated, responded to and reported to HIQA.

There were systems in place to ensure residents’ finances were appropriately safeguarded. There was a policy to guide staff on the management of residents’ personal property and possessions. A petty cash system was in place to manage small amounts of personal money for residents. A record of the handling of money was maintained for each transaction. Two staff signatures were present for all transactions.

There were policies in place about managing behavioural and psychological signs and symptoms of dementia (BPSD) and restrictive practices. Inspectors reviewed the care plans of residents with BPSD. There was evidence of regular review of residents by the Psychiatry of Older Age Consultant. Although staff could describe how to allay the residents’ concerns, there was no specific behaviour support plan available with details of proactive and reactive strategies to guide and inform staff and to ensure a consistent approach to the management of the behaviours expressed.

There was a policy available on restraint management (the use of bedrails and lap belts) in place but further work was required in order to achieve a restraint free environment. At the time of this inspection there were 50 residents with bedrails in use. On review, 28 of these were documented as enablers. Inspectors saw that where a bedrail was requested by a resident in order for them to feel safe or reposition them in bed, a risk assessment was completed to ensure the practice was safe. Inspectors saw that the enabling function was not always recorded in the risk assessment completed. There was evidence that less restrictive options were considered prior to the use of the restraint and signed consent was obtained.

A restraint/ enabler register was maintained. Inspectors saw records that indicated the times residents with bedrails were checked periodically throughout the night. Bumpers were fitted over some bedrails to minimise risk of injury for residents with poor skin integrity or those with involuntary movement.

**Judgment:**

Substantially Compliant

**Outcome 08: Health and Safety and Risk Management**

The health and safety of residents, visitors and staff is promoted and protected.

**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:
Risk management and learning from accidents and incidents that occurred required review. Inspectors found that the management of falls required review to ensure that there were appropriate arrangements for the identification, recording, investigation and learning from any serious incidents or adverse events involving residents. Inspectors reviewed the accident and incident log for the preceding period. There was a high number of unwitnessed falls and several occurred in communal areas. There was evidence that sensor mats were used to alert staff when residents were at high risk of falls but during the inspection it was observed that communal areas were unsupervised. There was no emergency call bell in these communal areas to alert staff if a resident sustained a fall. Relatives interviewed in the course of the inspection had complained about this however appropriate action had been taken to address this risk. Some accident forms were observed to be incomplete and it was not always evident that they were reviewed by the person in charge following the accident. Falls risk assessments were not always updated to reflect the incident and the increased risk. One resident had absconded from the centre on four occasions. The resident had been provided with a sensor alarm to alert staff if she left the building but there was no evidence that a missing person drill had been completed to ensure that staff were familiar with the procedure.

An audit of accidents and incidents was completed by the person in charge for the previous year. A risk register was established which was regularly reviewed and updated. The internal and external premises and grounds of the centre appeared safe and secure, with appropriate locks installed on all exterior doors and a register of visitors was maintained in both units. The centre was found to be visibly clean and clutter free. There was a policy around responding to emergencies available which identified temporary accommodation for residents in the event of an evacuation and contact details for local services. Appropriate fire safety measures were in place. Completed logs were maintained on daily, weekly, monthly and quarterly tests and checks of fire equipment, doors, exit routes and emergency lighting. Certification of testing and servicing of extinguishers, fire retardant materials and the alarm system were documented. The building’s fire and smoke containment and detection measures were appropriate to the layout of the building and exits were free of obstruction. All staff had received training in fire safety within the past 12 months and were familiar with what actions to take in the event of a fire alarm activation. There was evidence that fire drills were completed at regular intervals. Emergency lighting and fire fighting equipment, directional signage and appropriate fire procedures were available throughout the building.

There were hand sanitising gels provided throughout the centre and a colour coded cleaning system was in use to ensure infection control. Staff had completed training on moving and handling and were observed to implemented the principles when assisting
Judgment: Non Compliant - Moderate

Outcome 09: Medication Management
Each resident is protected by the designated centre’s policies and procedures for medication management.

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 medication management policy in place which provided guidance to staff to manage aspects of medication from ordering, prescribing, storing and administration. This required review as it did not reference the medication administration system in use.

Medication was delivered to the centre on a monthly basis by the pharmacist in individual weekly blister packs. All medicines were stored safely and the temperature of the medicine refrigerator was monitored and temperatures recorded. The prescription sheets were pre-printed by the pharmacist and signed individually by the General Practitioner. Photographic identification was available for each resident to ensure the correct identity of the resident receiving the medication and reduce the risk of medication error. The prescription sheets reviewed were legible. The maximum amount for (PRN) medication (a medicine only taken as the need arises) was indicated on the prescription sheets examined.

The medication administration sheets were signed by the nurse following administration of medication. Medication was administered within the prescribed timeframes. There was space to record when a medication was refused on the administration sheet.

Medications that required strict control measures were kept in a secure cabinet which was double locked. Inspectors checked a selection of the medication balances and found them to be correct.

Some medication was being crushed for some residents. Alternative liquid or soluble forms of the drugs were sought where possible through consultation with the pharmacy. Drugs being crushed were signed by the GP as suitable for crushing. Each resident had their own crusher for their medication.

Judgment: Compliant

Outcome 10: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.
**Theme:**
Safe care and support

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

**Findings:**
Inspectors reviewed a record of incidents or accidents that had occurred in the centre and cross referenced these with the notifications received from the centre. Quarterly notifications had been submitted to the Authority as required. Two incidents where a resident had absconded were not appropriately notified. These were subsequently submitted when this was brought to the attention of the person in charge.

**Judgment:**
Substantially Compliant

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**Outcome 11: Health and Social Care Needs**
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/ her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/ her changing needs and circumstances.

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**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:**
There were 60 residents in the centre during the inspection. 30 with maximum dependency care needs, 18 residents were assessed as highly dependent, 11 had medium dependency care needs and one resident was assessed as low dependency care needs. Residents had a range of healthcare issues and the majority had more than one medical condition. A preadmission assessment was completed to ensure the centre could meet the needs of prospective residents. Residents had good access to GP and consultant geriatrician services. Regular reviews of residents overall health was found on admission, readmission following return from acute hospital care and as required when clinical deterioration was noted. There was evidence of access to specialist and allied health care services to meet the care needs of residents such as opticians, dentists and chiropody services. Access to palliative care specialists, dietician, physiotherapy and speech and language was also available.
Significant improvements were identified with the standard of care planning. Audits had been completed by staff in advance of the inspection however these did not consider the effectiveness of the care plans or ensure that they were sufficiently detailed to guide care. Each resident had some care plans completed. Some care plans had not been reviewed four monthly or in response to a change in the residents’ condition as required by the regulations. For example one resident with difficulty swallowing and low weight had been assessed by a dietician and speech and language therapist however her care plan did not included the advice of either.

Some care plans reviewed by inspectors were generic and lacked sufficient detail to guide staff and manage the needs identified. For example; one resident was prone to respiratory chest infections however the care plan did not prompt staff to request a sputum sample or guide care when the resident had an infection. Another resident had a care plan developed post eye surgery. The goal in the care plan was to prevent any post surgery complications; however, this care plan had not been either reviewed or discontinued in over 6 months. In some instances it was apparent from the daily notes that there was a significant change in the residents’ condition but the inspectors saw that the residents care plan had ‘unchanged’ recorded. There was poor evidence that the resident or his or her family were involved in the reviews of the care plans. There appeared to be poor understanding of the purpose of the care plan. For example where residents had impaired mobility, the care plans reviewed made no reference to the type of assistive equipment they required or if the required a hoist the type of hoist and sling size was not referenced.

A number of risk assessment tools were used to evaluate clinical risks such as the risk of sustaining a fall or weight loss or developing a pressure ulcer, however, some were poorly completed and others hadn’t been reviewed in over four months or in response to a change in need. For example, one falls risk assessment had not been reviewed even though the resident had sustained a fracture from a fall. In another instant, a residents’ nursing assessment of their needs in relation to the activities of daily living had not been reviewed in 8 months. Daily nursing progress notes reviewed were found to be very clinical in nature and did not give a clear and accurate picture of residents’ overall health. The person in charge was made aware of the non compliances identified and inspectors were assured that a full review of all care plans would be immediately commenced.

Inspectors identified that wound care was not reflective of evidence based practice. The care plans of three residents with pressure ulcers were reviewed. Wound assessment charts were found to be poorly completed and the treatment plan in place was not evidence based. Some residents’ wounds had resolved and other wounds had improved however there were poor procedures in place for measuring a wound to ensure that there was a base line obtained for comparative purposes to monitor whether the wound was progressing or regressing. While photographs were available for some wounds, these were not always taken regularly and some were not dated. Measurements of the wound were also not consistently recorded. This presented a difficulty in monitoring wounds for any changes. Inspectors were told that the camera was broken at the time of the inspection. Residents with wounds were referred to dietician and to a tissue viability specialist but the wound care plans reviewed did not contain sufficient information to guide good evidence based care. As a result of these findings, inspectors
met with the person in charge and the deputy director of nursing. On the morning of the second day of the inspection, arrangements had been made for a tissue viability specialist to visit the centre to review all residents with wounds and those at risk of developing wounds. Care bundles were put in place and a staff member who had completed training in wound care was also rostered so that she could shadow the tissue viability specialist to complete her training and would become a link nurse in wound care. The person in charge also confirmed that a new camera was ordered on the second day of inspection. The person in charge has been requested to submit a weekly update on each resident with a wound and she has complied with this requirement.

Some residents had a formal diagnosis of dementia and others had some element of cognitive impairment. Inspectors observed staff to be patient and they promoted their independence and reassured residents. There was evidence in the care plans of links with the mental health services and referrals were made to the consultant psychiatrist to review residents and their medication to ensure optimum health. However, the way in which the dementia impacted on the resident was not always clearly described in the care plan so it was difficult to see how it was assessed. For example, level of dementia the resident presented with or the level of orientation the resident retained was not recorded in their care plans.

There were some opportunities for residents to partake in activities but some activities described in the schedule were not meaningful, for example ‘the library and lunch’ were listed as activities. A therapy dog visited the centre every week and music and art therapy also took place weekly. There was a coffee shop at the entrance to the centre which was enjoyed by residents however this closed in the evenings and at weekends. The person in charge told inspectors that plans were been made to extend the opening hours of this amenity. There were several residents who spend long periods in their bedroom but there was poor evidence of any one to one activities for these residents. It was apparent from minutes of residents meetings and from discussions with residents, relatives and staff that there were not enough organised activities to keep residents engaged in a meaningful way.

Judgment:
Non Compliant - Major

Outcome 12: Safe and Suitable Premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents’ individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Effective care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.
Findings:
The building is designed to meet the needs of dependent older people. It consisted of 2 distinct units each laid out over two floors. Lifts are provider between floors. The building is a modern design which with large areas of glass which maximises the natural light. It was warm, comfortable, well decorated and visually clean. There was a high standard of décor throughout and good levels of personalisation evident in residents’ bedrooms. Residents spoken with confirmed that their rooms were comfortable. The maintenance both internal and external was of a very good overall standard. Maintenance staff were observed on site at the centre and service contracts for repair of equipment such as the lift and fire alarm were up to date. Assistive equipment was available for use and in good working order.

Although there was a range of communal areas available, some were observed to be under used. At the entrance to the nursing home there is a large coffee shop which was used by residents, staff and visitors to the centre which provided a social area for residents to spend time and enjoy a meal or snack away from their unit. The coffee shop was run by an external organisation at the time of the inspection and closed at 4pm every evening and at weekends. The person in charge and acting director of nursing indicated they were in discussions to extend the opening times to allow residents to enjoy this amenity in the evenings and at weekends. This would afford more choice to residents as there was only one communal area available on each floor which served as both a sitting room and dining room.

There were two additional rooms located on the ground floor off the coffee shop area which had recently been brought back in to use for residents and these were available for visitors or private parties. At the time of the inspection these were not observed to be used and residents mainly remained in the sitting room /dining area. A purpose built hairdressing salon and oratory were also available.

In total there are 30 single en-suite bedrooms and 20 double en-suite bedrooms. All en-suites were observed to be fully accessible and screens were provided between beds in the double rooms. Bedrooms had televisions provided. There was a nurse’s station provided on each floor. There was a call bell system linked to a hand held monitored carried by staff at each resident’s bed however as discussed under outcome 8, there was no emergency call bell provided in the communal areas. There were a sufficient number of toilets, baths and showers provided for use by residents and toilets were located close to communal rooms for residents’ convenience. A safe garden was available to residents off each unit however it was evident during the inspection that this was not regularly used except by residents that smoked.

Judgment:
Substantially Compliant

Outcome 13: Complaints procedures
The complaints of each resident, his/ her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.
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 policy available and the procedure for making a complaint was displayed in the foyer. The complaints procedure included an independent appeals process if the complainant was not satisfied with the outcome however this was unclear and referred to the Health Services Executive rather than an individual who would independently review a complaint if necessary.

Inspectors reviewed the complaints log during the inspection. There were 29 recorded complaints. Some complaints were still being investigated at the time of inspection. The complaints log evidenced that all complaints were responded to in a timely manner and that actions taken were relayed to the complainant. However, it did not indicate if the outcome was relayed to the complainant and if they were satisfied with the outcome of the complaint.

Judgment:
Non Compliant - Moderate

Outcome 14: End of Life Care
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:
Person-centred care and support

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

Findings:
Each resident had a plan of care for end-of-life needs. The care plans contained good detail of the residents’ personal or spiritual wishes. Decisions concerning future healthcare interventions were clearly outlined. Resident’s preferences with regard to transfer to hospital if of a therapeutic benefit were documented in end-of-life care plans. Inspectors reviewed the file of a recently deceased resident and it was evident from the nursing notes that care was provided in accordance with the residents wishes.

Some residents had with a do not attempt resuscitation (DNAR) status in place. Inspectors saw that the status was reviewed to assess the validity of the clinical judgement on an ongoing basis. There was an end-of-life care policy to guide staff and those staff spoken to confirmed that they had good access to the palliative care team who provided advice to monitor physical symptoms and ensure appropriate
comfort measures.

**Judgment:**
Compliant

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**Outcome 15: Food and Nutrition**

*Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.*

**Theme:**
Person-centred care and support

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

**Findings:**
Residents’ individual food preferences were recorded on admission and this information was recorded in the nutritional care plan. All residents were screened for nutritional risk on admission using a recognised assessment tool. Inspectors saw that residents' weights were checked monthly or more frequently where indicated. Where residents were identified as been at risk nutritionally they were referred to a dietician and those who had an impaired swallow were reviewed by a speech and language therapist. Care was provided according to the recommendation of the specialist although this information was often not included in the nutritional care plans. There was poor linkage between some assessments completed and the care plan. For example inspectors reviewed a nutritional assessment for a resident who had lost weight. A dietician had reviewed the resident and had stated that she would review the resident again if further weight loss was experienced. There was no evidence that this had occurred even though the residents’ weight had reduced. The care plan hadn’t been reviewed to reflect the change in the residents’ nutritional needs. Food and Fluid intake charts were maintained for residents assessed as being at risk of weight loss but inspectors found that some were not completed in sufficient detail to provide a reliable therapeutic record of the residents’ nutritional intake over a 24 hour period. Actions have been included under outcomes 5 and 11 on care planning to address these findings.

Inspectors observed the residents during their lunch and their evening meal. There was a choice of meals provided and residents on modified diets were given the same choice as other residents. Staff sat beside the resident to whom they were giving assistance and were noted to patient 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.

Residents with an impaired swallow were seated in an upright position in accordance with the advice of the Speech and Language therapist to prevent aspiration. Special dietary requirements were communicated to the catering staff. Inspectors met with the
chef who had a list with names of each resident who required a modified diet and those on weigh reducing or diabetic diets. Drinks such as water, milk, tea and coffee were available. Access to fresh drinking water at all times was available, jugs of water were observed in residents' rooms and water jugs were available.

**Judgment:**
Non Compliant - Moderate

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**Outcome 16: Residents' Rights, Dignity and Consultation**
Residents are consulted with and participate in the organisation of the centre. Each resident’s privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

**Theme:**
Person-centred care and support

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

**Findings:**
Staff were observed to interact with residents in a personal manner. There was evidence that residents rights, privacy and dignity was respected. Double rooms had privacy screens and all personal care was delivered in the resident’s bedroom. All bathrooms had privacy locks fitted.

There were no restrictions to visiting in the centre and some residents were observed spending time with family or friends in the coffee shop and reading newspapers or chatting in their bedrooms. Residents could use one of the communal rooms near the entrance to the centre if they wanted to receive visitors in private. The Sisters of Nazareth support the centre with daily pastoral care. A Church of Ireland minister also visited the centre regularly. There is an oratory on site where mass is said daily. Residents said their choice was respected and they were asked if they wished to attend Mass or activities.

There were several residents who spend long periods in their bedroom but there was poor evidence of any one to one activities for these residents. Some residents and relatives commented in the questionnaires completed in advance of the inspection that there were not enough organised activities to keep residents engaged in a meaningful way. Minutes of residents meetings held recently also reflected the same concern. An activity schedule was displayed however some activities described were not meaningful, for example ‘the library and lunch ’were listed as activities. The person in charge stated that the provision of meaningful activities for residents was an area which she had planned to develop and an activities coordinator was been recruited and two staff had recently completed training in Sonas training (a therapeutic activity for residents who are cognitively impaired).
A therapy dog visited the centre and music and art therapy also took place weekly. The
coffee shop at the entrance provided a social outlet for residents and was observed to
be very well used during the day however, this closed in the evenings and at weekends
which would be busy visiting times. The person in charge told inspectors that she
planned to address this and extend the opening hours of this amenity.

The contact details for an independent advocate were displayed in the centre.
Inspectors reviewed minutes of consumer group meetings. Inspectors saw that
meetings had not taken place from March 2015 to April 2016. The person in charge
stated that the forum had only recently been re-established and she planned to ensure
meetings took place meeting should be held meetings every 6 weeks. Minutes of a
meeting held in June were reviewed and included discussions about the food, operating
hours of the coffee shop and support services provided such as physiotherapy.
Requests for more activities and exercise were also recorded in the minutes reviewed.

Judgment:
Non Compliant - Moderate

Outcome 17: Residents' clothing and personal property and possessions
Adequate space is provided for residents' personal possessions. Residents can
appropriately use and store their own clothes. There are arrangements in
place for regular laundering of linen and clothing, and the safe return of
clothes to residents.

Theme:
Person-centred care and support

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

Findings:
Adequate space was provided for residents’ personal possessions and clothing was
stored in a neat and appropriate manner.
A policy on residents' personal property was in place and implemented using an
inventory on clothes and valuables belonging to residents upon admission. Inspectors
observed that a property lists were maintained for all residents however this was not
detailed and were not always updated when new items were brought to the centre.

There were arrangements in place for regular laundering of linen and clothing however
inspectors found that this service was not adequately staffed. Clothing was labelled for
the laundry and each resident had an individual laundry basket. Sheets and bed linen
were sent out of the centre for laundering. There was only one staff member employed
to do laundry for 60 residents and this person was employed by a separate company
two days each week. Inspectors observed that some labels had fallen off clothing and
the laundry staff member said she didn't always have time to re attach them. Feedback
received in questionnaires returned by both residents and relatives also commented on
items of clothing being mislaid from time to time.
Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

Outstanding requirement(s) from previous inspection(s):

Findings:
Inadequate staffing levels and skill mix was the subject of an action plan from the last two inspections of this centre and although the provider had responded by completing a review of staffing levels and increasing staff levels in the evening, Inspectors found evidence that the allocation and deployment of staff was not adequately meeting the needs of residents. A copy of the staffing roster was reviewed by the inspector. The normal allocation of staff on duty was four nurses and ten care assistants during the day from 08.00 until 15.45. This reduced to two nurses and ten care assistants in the evening until 20.15. At night time there were two nurses and four care assistants on duty. Observations of the centre layout, discussions with residents, relatives and staff and from analysis of the questionnaires returned by residents and families, inadequate staffing levels was a constant theme raised. The centre is arranged in two distinct units some distance apart and each arranged over two floors. The entrance to the centre was not staffed at night and this is likely to contribute to this perception Relatives complained to inspectors that there staffing levels were not sufficient and that when they visited at night staff were difficult to find. Bedrooms were set back off the corridor and staff attending to a resident would not be visible.

Inspectors observed during the inspection that communal areas were regularly unsupervised and there was evidence recorded of a high number of unwitnessed falls occurring. On several occasions during the inspection, the inspector observed residents left unsupervised for long periods of time.

A training plan for 2016 was available and it included mandatory and clinical care updates such as pressure ulcer prevention; assessment and care planning dementia care and person centred care. On observation of areas such as care planning, wound care and falls prevention however, the training provided did not appear to be implemented in
practice. There was an apparent lack of clinical supervision which was evident from the findings in outcome 11.

The inspector reviewed a sample of staff files and found that the required documentation was in place in line with the requirements of Schedule 2 of the Regulations. The inspector requested the an Bord Altranais agus Cnáimhseachais na hÉireann registration numbers for all nursing staff and found that all were in place.

**Judgment:**
Non Compliant - Major

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**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:**

Marie Matthews
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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Nazareth House Nursing Home Sligo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000369</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>22/06/2016</td>
</tr>
<tr>
<td>Date of response:</td>
<td>19/09/2016</td>
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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 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Audits completed during 2015 had not yet been collated in a quality improvement plan in consultation with the residents.

1. Action Required:
Under Regulation 23(e) you are required to: Prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.

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:
A review of the audits conducted in 2015 is under way and a quality Improvement plan developed indicating the findings of these audits. A Focus Group will be established to consult on the audit and quality improvement plan which can then be discussed at the Resident’s Group meeting.

The Organisation Chart was updated at September 2016

PPIM forms for two recently appointed Clinical Nurse Managers have been completed. A PIN is awaited for one CNM before the forms are sent to the Inspector. The PPIM Form for the recently appointed HR Manager and for one CNM were sent to the Inspector on 07/09/2016.

Proposed Timescale: 30/10/2016

Outcome 03: Information for residents

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints procedure was not clearly summarised in the guide in a manner which allowed the resident to clearly understand the procedure.

2. Action Required:
Under Regulation 20(2)(c) you are required to: Prepare a guide in respect of the designated centre which includes the procedure respecting complaints.

Please state the actions you have taken or are planning to take:
The Residents Guide has been reviewed and amended to ensure the complaints procedure is summarised in a clear and concise format that Residents can understand.

The Complaints procedure summary is clearly displayed throughout the Nursing home.

Proposed Timescale: 30/09/2016

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Any additional cost not covered by the overall fee were not clearly explained in the contract of care.

3. Action Required:
Under Regulation 24(2)(b) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the fees, if any, to be charged for such services.

**Please state the actions you have taken or are planning to take:**
All contracts of care now have an appendix attached outlining any additional charges for services that the Resident may avail of.

**Proposed Timescale:** 16/09/2016

**Outcome 05: Documentation to be kept at a designated centre**

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some care documentation, including residents care plans, were poorly completed and lacked sufficient detail to guide care.

4. **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:**
A review of the relevant Policies and procedures to ensure that they reflect national policy will be completed by 30th November 2016

A documented handover process will be introduced to enhance communication between Staff from one shift to another and will commence 7th October.

PIC has held meetings with Nursing Staff to reiterate the use of Wound care Bundles is Complete

Education for Staff on Care plan formation to ensure it will be reflective of the care delivered will be completed by 30th October 2016

One to one nurse training on the purpose of the care planning process from assessment, planning implementation and evaluation will be completed by 30th October.

All assessment tools will be evaluated and monitored by the Clinical Nurse Managers by 30th October 2016.

A full review of all care plans has commenced to ensure that they are person centred and updated as changes occur in the Residents needs. This will be completed by 30th October 2016.
Care Planning/Documentation Training will be conducted with all staff in relation to the new computerised care documentation system to be introduced by 30th March 2017.

The records set out in Schedule 2, 3, and 4 will be kept in the designated centre and are available for inspection by the Chief Inspector.

Proposed Timescale: As Above

Outcome 07: 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:
Although staff could describe how to allay the residents’ concerns, there was no specific behaviour support plan available with details of proactive and reactive strategies to guide and inform staff and to ensure a consistent approach to the management of the behaviours expressed.

5. Action Required:
Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

Please state the actions you have taken or are planning to take:
The PIC will organise Education/Support for Staff in relation to the monitoring of behaviours that challenge using the Newcastle model. These findings will identify the triggers that lead to displays of behaviours that challenge. Appropriate management measures to assist in the safe de-escalation of such behaviours that challenge will be identified.

Behaviour Support plans will be put in place for those Residents with behavioural issues in order to manage and respond to behaviour that is challenging or poses a risk to the residents concerned or to other persons in so far as possible, in a manner that is not restrictive with details of proactive and reactive strategies to guide and inform staff and to ensure a consistent approach to the management of the behaviours expressed.

Proposed Timescale: 30/11/2016
## Outcome 08: Health and Safety and Risk Management

### Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence that a missing person drill had been completed to ensure that staff were familiar with the procedure.

6. **Action Required:**
Under Regulation 26(1)(c)(ii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the unexplained absence of any resident.

Please state the actions you have taken or are planning to take:
The missing person’s policy has been updated in line with practices and procedures regarding missing person’s drills. Complete 1st September 2016

Quarterly Missing persons Drills will be conducted commencing in the week of October 3rd 2016.

All Staff to attend a missing persons drill update on an annual basis.

#### Proposed Timescale: 30/11/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The arrangements for the identification, recording, investigation and learning from any serious incidents or adverse events involving residents required review.

7. **Action Required:**
Under Regulation 26(1)(c)(iii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.

Please state the actions you have taken or are planning to take:
A review of reportable Incidences has been undertaken and new Practices will ensure all Incident forms are now reviewed by the PIC to monitor trends of incidents ensuring all appropriate measures were taken to minimise the incident/risk reoccurring ------- Completed 29th July 2016

A falls Register/Diary is now maintained as well as a trend monitor poster for staff awareness and learning-----Completed 29th July 2016
A Physiotherapist was engaged by the centre to assist in falls management—Completed 29th July 2016

All Residents are reassessed post fall by the Physiotherapist—Complete 29th July 2016

All Falls risk assessment scores will be updated after each fall—Complete 29th July 2016

A Root cause analysis tool to determine cause of falls and accidents with corrective/preventative actions to inform practice to continually improve the Quality of care is under development.

**Proposed Timescale:** 30/11/2016

**Outcome 11: Health and Social Care Needs**

**Theme:**
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Significant improvements were identified with the standard of care planning. Some care plans had not been reviewed four monthly or in response to a change in the residents’ condition as required by the regulations. Some were generic and lacked sufficient detail to guide staff and manage the needs identified.

**8. 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:**
A full review of the care plan documentation has commenced and will be complete 30th October 2016.

A documented handover process will be introduced to enhance communication from shift to shift.
7th October 2016

A daily care record tool to support individualised care and planning of care is under development to assist in care delivery and documentation of care undertaken.
1st October 2016

One to one Nurse training on the purpose of care planning process, Implementation and evaluation will be undertaken.

All assessment tools will be evaluated monthly.
All care plans will be developed within the 48 hour timeframe

Care plans will be person centred and updated as changes occur to reflect the current plan of care of the Resident.

Care plans will be reviewed at a minimum on a four monthly basis or where there is significant change in the Residents condition by the link nurse for each Resident in conjunction with the family and Resident and reviewed by the CNM.

The above will be monitored by the PIC who will conduct care plan audits on alternate months.

All care plans will be individualised. There will be a change in practice introduced ensuring all care plans are person specific and not generic in nature. PIC will guide nursing staff in relation to these practices.

**Proposed Timescale:** 30/11/2016  
**Theme:** Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Care plans were not reviewed every four months or where there was a significant change in the residents’ condition

**9. 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:**  
Formal care plan reviews will be conducted at a minimum on a four monthly basis or where there is a significant change in the residents condition by the link nurse for each Resident in conjunction with the family and Resident and reviewed by the CNM.

All reviews will be diarised on a four monthly basis with the Resident and his/her family
There was poor evidence that the resident or his or her family were involved in the reviews of the care plans.

10. **Action Required:**
Under Regulation 05(5) you are required to: Make the care plan, or revised care plan, prepared under Regulation 5 available to the resident concerned and, with the consent of that resident or where the person-in-charge considers it appropriate, to his or her family.

**Please state the actions you have taken or are planning to take:**
Nursing practice will now ensure all care plans will be available to the resident concerned and, with the consent of that resident or where the person-in-charge considers it appropriate, to his or her family. The care plan will be discussed/reviewed with the Resident or family member at the time of formal review on a four monthly basis. A record of this review will be available within the Residents file.

All reviews will be diarised on a four monthly basis with the Resident and his/her family.

**Proposed Timescale:** 30/11/2016

**Theme:**
Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Practice in relation to wound care and falls prevention was not reflective of evidence based practice.

11. **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:**
PIC advised all staff of new practices in relation to wound care. New procedures set out that all wounds, skin tears and bruising are reportable incidents and that an Incident form must be completed when any of these occur. ------Complete 29th July 2016

Completion of wound care bundles is standard practice. ------Completed 29th July 2016

All wounds are photographed, assessed and measured on a weekly basis or as required to allow for comparatives and effectiveness of treatments. Completed 29th July 2016

Link Nurse will be relieved of her duties to allow them time with the Tissue Viability Nurse specialist to gain more clinical exposure in relation to wound care management. 30th October 2016
PIC to monitor wound development and management by conducting monthly audits.

A new Physiotherapist was engaged by the Centre-----Completed 29th July 2016

All Incident report forms for falls will be reviewed by PIC------Completed 29th July 2016

All Residents will be reassessed post fall by the Physiotherapist------Completed 29th July 2016

A Falls Diary was introduced----Completed 29th July 2016

Monthly audits of falls will be conducted by PIC

Proposed Timescale: 30/10/2016

Outcome 12: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Although there was a range of communal areas available, some were observed to be under used. A safe enclosed garden was available to residents off each unit however it was evident during the inspection that this was not regularly used except by residents that smoked.

There was no emergency call bell provided in the communal areas.

12.  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:
A full review of the use of the communal areas has been undertaken and it is planned to:
Maximise the use of the communal areas within the centre

The coffee dock opening hours have been extended to weekend opening on a trial basis for six weeks but the uptake does not warrant or cover the cost of the operation. However this trial will continue and promotional activities are underway.

The use by residents of other communal areas in the centre is under consideration while safety issues/risk assessments will have to be undertaken and addressed in the first instance. This is under review by the Board.
Emergency Call bells have been installed in each of the four communal areas used by Residents-------- complete 30th August 2016

While the garden is not presently an enclosed area, a garden, situated between the two units, has been identified that could be used but would have to be made safe with resultant substantial works. This is under review by the Board.

**Proposed Timescale:** 30/06/2017

**Outcome 13: Complaints procedures**

**Theme:**
Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The complaints procedure included an independent appeals process but this was unclear as to how it operate and to whom an appeal was made.

**13. Action Required:**
Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.

**Please state the actions you have taken or are planning to take:**
PIC will review the complaints policy and procedures to ensure they clearly identify an independent Individual who would review complaints if necessary.

**Proposed Timescale:** 30/09/2016

**Theme:**
Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The complaints forms reviewed did not always evidence if the complainant was satisfied with the outcome of the complaint or if they made aware of the complaints procedure.

**14. Action Required:**
Under Regulation 34(1)(g) you are required to: Inform the complainant promptly of the outcome of their complaint and details of the appeals process.

**Please state the actions you have taken or are planning to take:**
Each complainant will be advised of the complaints procedure.

The complaints forms will now evidence if the complainant was satisfied with the
The PIC will ensure that the complainant is promptly informed of the outcome of their complaint and details of the appeals process.

Complaints will be audited on a Monthly basis by the PIC and by the Independent Person on a regular basis.

**Proposed Timescale:** 30/08/2016

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## Outcome 16: 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:**
There were not enough organised activities to keep residents engaged in a meaningful way.

**15. 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 Centre will identify Resident’s interests in relation to social activities. A questionnaire process will be conducted to gather this information. This will then assist in the advancement of the activities programme.

The centre will develop relations between our Residents and external agencies through the redevelopment of the Volunteer programme.

The centre will establish an activities steering committee which will comprise of Residents, Family members, Staff and management representative.

The extension of the opening hours of the coffee dock to allow the Residents access the services at weekends has enhanced the connectivity between the residents and the community as a result of the mingling in the coffee dock.

An Activities Co-ordinator position was advertised on web but no suitable candidates applied. Advertisement in local newspapers is ongoing. Plan to fill the post in October subject to sourcing a suitable candidate.

In the meantime, staff have taken an active role in supporting residents in meaningful activities – i.e. music night, baking, flower arranging, art therapy, reminiscence. Pastoral care continues to be very evident in the nursing home.
Proposed Timescale: 30/12/2016

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence that regular meetings of the consumer group took place to ensure residents were consulted and involved in decisions about the centre.

16. Action Required:
Under Regulation 09(3)(d) you are required to: Ensure that each resident is consulted about and participates in the organisation of the designated centre concerned.

Please state the actions you have taken or are planning to take:
Consumer Group meetings will continue at intervals of six week periods between Residents and management to assist in the planning of service development. Resident’s meetings (every eight weeks) are now minuted and copies of the minutes are circulated. An action plan of items raised are recorded with follow up results.

Completed 1st August 2016

PIC will seek feedback from Residents and/or their families through satisfaction surveys on an annual basis. This information will assist in the future planning and development of services.

Proposed Timescale: 01/12/2016

Outcome 17: Residents’ clothing and personal property and possessions

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The systems in place for ensuring residents laundry was safely laundered and returned to the resident required review. Feedback received in questionnaires returned by both residents and relatives commented on items of clothing being lost. Inspectors observed that property lists were not detailed and were not always updated when new items were brought to the centre.

17. Action Required:
Under Regulation 12(b) you are required to: Ensure each resident’s linen and clothes are laundered regularly and returned to that resident.

Please state the actions you have taken or are planning to take:
The Carers Key working system is reviewed to reflect the new staff changes. Care Staff
will update the property lists of their Key Residents at three monthly intervals or as required.

Operations within the Laundry continue to be reviewed to ensure the service continues over a five day period but will no longer be closed for two consecutive days. This will allow for a more structured and efficient service delivery.

The laundry is monitored on a daily basis.

Procedures in relation to non-labelled laundry items has been reviewed and the Laundry Staff will liaise with the Care Staff to ensure the owners of Items are identified and relabelled at the earliest convenience.

The Laundry roster was reviewed in July with necessary increases hours put in place as well as analysis of workload on different days.

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**Proposed Timescale:** 30/09/2016

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**Outcome 18: Suitable Staffing**

**Theme:**
Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The allocation and deployment of staff was not adequately meeting the needs of residents.

**18. 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:**
Staffing levels within the Nursing home are determined by the use of a tool which guides Management in the required staffing levels based on the Residents Dependency Levels and care needs.

The shift pattern for the Staff Nurses has been altered to ensure there are two Nurses on duty on each unit until 18.00hrs in the evening. PIC will continue to conduct monthly Staffing reviews/roster or more often if circumstances change.

Since the inspection in June two CNM’s are now in place, three nurses have commenced with another commencing in mid-September.

PIC will continue to work with the HR manager to ensure the recruitment is planned and more robust.
The improved skill mix and the increased nursing hours has enhanced clinical supervision.

Daily staff allocation is completed by a Senior Staff member to ensure a safer environment.

A monthly Quality Improvement Plan has been introduced as standard practice.

Opening hours at the Reception area is under review.

**Proposed Timescale:** 30/09/2016