

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Nazareth House
<b>Centre ID:</b>	OSV-0000368
<b>Centre address:</b>	Fahan, Lifford, Donegal.
<b>Telephone number:</b>	074 936 0113
<b>Email address:</b>	john.omahoney@nazarethcare.com
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Sisters of Nazareth
<b>Lead inspector:</b>	Sonia McCague
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Unannounced Dementia Care Thematic Inspections
<b>Number of residents on the date of inspection:</b>	47
<b>Number of vacancies on the date of inspection:</b>	1

## **About Dementia Care Thematic Inspections**

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

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

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

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

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

**The inspection took place over the following dates and times**

From:	To:
16 October 2018 12:30	16 October 2018 19:00
17 October 2018 08:00	17 October 2018 13:30

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

<b>Outcome</b>	<b>Provider's self assessment</b>	<b>Our Judgment</b>
Outcome 01: Health and Social Care Needs	Substantially Compliant	Non Compliant - Moderate
Outcome 02: Safeguarding and Safety	Compliance demonstrated	Non Compliant - Moderate
Outcome 03: Residents' Rights, Dignity and Consultation	Compliance demonstrated	Substantially Compliant
Outcome 04: Complaints procedures	Compliance demonstrated	Compliant
Outcome 05: Suitable Staffing	Compliance demonstrated	Non Compliant - Moderate
Outcome 06: Safe and Suitable Premises	Substantially Compliant	Substantially Compliant
Outcome 08: Governance and Management		Non Compliant - Moderate

**Summary of findings from this inspection**

As part of the thematic inspection process, providers were invited to attend information seminars given by given by The Office of the Chief Inspector. In addition, evidence-based guidance was developed to guide the providers on best practice in dementia care and the inspection process.

Prior to the inspection, the provider and the person in charge completed the self-assessment and scored the service against the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland. The previous table outlines the self-assessment and the inspector's rating for

each outcome.

The centre provides a service for up to 48 residents with 47 residents in occupancy during the inspection. The centre provides long stay and respite care. On the day of the inspection there were 22 (47%) residents with a diagnosis of dementia and nine suspected as having dementia.

The inspector met with residents, relatives and staff members during the inspection. The journey of a number of residents with dementia was tracked. Care practices and interactions between staff and residents including those with dementia were observed. Policies and documentation such as care plans, medicine and medical records, rosters and staff training records was reviewed.

Residents who spoke with the inspector were very positive about the centre and the staff team, and by and large their relatives shared this view. Both residents and staff were complimentary about the recent return of the long-standing person in charge.

Residents were positive about the support provided by staff, and in the main the inspector observed good communication approaches to residents throughout the centre. However, the communication arrangements between staff in relation to the changing needs and interventions prescribed for residents had not been sufficiently communicated or recorded appropriately. Deficiencies in the governance and management arrangements existed and positions vacant for a deputy to the person in charge and nurses existed due to recent staff absences.

During the review of residents' care records delays were encountered. Computer records and information was not readily available and accessible in a timely fashion, when required. The review of care records showed residents' needs were being assessed and considered, however, care plans had not been developed for identified needs and others had not been reviewed on a regular basis or updated accordingly. Gaps within the assessment, care planning and evaluation process were found.

While there were sufficient staff numbers during the inspection, a review of staff skills and training was required to ensure they had sufficient knowledge and competency to meet the needs and changing needs residents.

Residents confirmed to the inspector they felt safe, and staff confirmed they knew the policy and procedure to ensure residents were safeguarded in the centre. Opportunities for occupation and recreation were available. However, support provided to residents with responsive behaviours and communication difficulties was not sufficiently planned or responded to. The implementation of approved policies and procedures that had not been demonstrated in practice and some required review and communication to all staff.

There were systems in place to support residents making choices about their daily lives. The person in charge who had recently returned from a planned leave of absence along with the staff team strived to promote the values of dignity and respect of residents' choices and preferences. Residents' were able to provide feedback on the service they received either directly to staff, in surveys or during

residents meetings. If they had complaints, the policy was clear, and information about the process was available in the reception area within the centre.

The premise was purpose built, and it supported residents' privacy and dignity. There were a range of rooms for activity, relaxation, prayer and social gatherings. Residents had good access to outdoors with an enclosed courtyard and sensory garden at the rear that was highlighted by residents and family members as a popular place. From the communal day rooms there were spectacular views of the countryside and Lough Swilly. Some consideration was required in relation to the preference of residents in shared bedrooms to be accommodated in a single room at the end of life.

The findings are discussed within the body of the report and areas for improvement required by the registered provider (11) and person in charge (eight) are outlined within the action plans at the end for response.

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

*Outcome 01: Health and Social Care Needs*

**Theme:**

Safe care and support

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

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

**Findings:**

This outcome sets out the inspection findings relating to assessments and care planning, access to healthcare, maintenance of records and policies available governing practice. The social care of residents with dementia is reported in Outcome 3.

The self-assessment tool (SAT) completed by the provider was rated substantially compliant in this outcome with some areas for improvement highlighted. An improvement outlined in this outcome included a new pre-admission assessment had been introduced on 10 September 2018 to have a dementia specific care pathway. This process and other areas associated with the assessment, care planning, communication of information between practitioners, implementation of policies and management of medicines required significant improvement and are discussed in the body of the report.

At the time of inspection, the inspector was informed that none of the residents were represented by a ward of court order or an enduring power of attorney.

The inspector focused on the experience of residents with dementia and tracked the journey prior to and from admission of residents diagnosed and suspected with dementia. Specific aspects of care such as nutrition, wound care, mobility, access to health care and supports, medicine management, end of life care and the maintenance of records were reviewed. During the review of residents' care records delays were encountered. Computer records and information was not readily available and accessible in a timely fashion, when required.

Arrangements were in place to support communications between the resident and family, and or the acute hospital and other centres, however, all relevant documents such as a medical, General Practitioner (GP) or Common Summary Assessments Report (CSAR) and an original prescription detailing current medicine regimes was not consistently obtained on or following each admission.

An admission policy was available; however, it was not sufficiently detailed to guide best

practice. The nurse or person in charge visited prospective residents in hospital prior to admission. This arrangement was positive and gave the resident and or their family an opportunity to meet in person, provide information and assess or determine if the service could adequately meet the current needs of the resident. The person in charge was aware that a CSAR was completed by professionals for residents funded under the Nursing Home Subvention Scheme (NHSS), but said she had difficulty in obtaining a copy from the referral source.

Residents had a nursing assessment completed on admission. The assessment process involved the use of validated tools to assess resident's dependency level, risk of malnutrition, falls and mobility, their skin integrity and pain level. However, as changes occurred, a revised or complete assessment of an identified need was not maintained or recorded. Examples of this were found in relation to the assessment of wounds, responsive behaviour and restraint usage and seizure activity.

As a result, an associated or specific care plan was not developed for review and to aid evaluation of interventions and treatments prescribed or given. Gaps in the care planning and review process were evident and assessments carried out by allied health care professionals had not been referenced or reflected within existing care plans to guide staff and ensure agreed best practice.

Access to a GP on a weekly or as required basis was confirmed during this inspection. Access to allied healthcare professionals including physiotherapy, dietetic, speech and language, occupational therapy, tissue viability, dental, ophthalmology and podiatry services was also confirmed and was facilitated on a referral basis. The Inspector was informed that residents had access to a community psychiatry nurse but that this service had been reduced in recent times due to the demand locally. From the cases tracked it was evident that this service had been available to some residents prior to and since their admission. Systems were in place in relation to transfers and discharge of residents and hospital admissions.

One resident had a healed pressure ulcer, another had a moisture lesion and others wounds included chronic leg ulcers. The inspector reviewed the wound care for residents and found that significant improvement was required in relation to the assessment, recording, reporting and care planning processes due to the gaps identified and reported to staff.

Residents identified at risk of developing pressure ulcers had specific equipment in place to mitigate the risk, such as repositioning regimes, pressure relieving mattresses and cushions, however, a review of the effectiveness of devices in use for some residents had not been re-assessed or reviewed.

Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked on a monthly basis, and more frequently when indicated. A review by a dietician and or speech and language therapist was prompted following these assessments and reviews.

The inspector saw that a choice of meals was offered and available to residents. There was the system of communication between nursing and catering staff to support

residents with special dietary requirements. Mealtimes in the dining room were unhurried social occasions and staff sat with residents while providing encouragement and assistance with their meal. Some residents choose to dine in their own bedrooms or elsewhere, and this was facilitated.

Staff provided end of life care to residents with the support of their GP and community palliative care services. 'End of life' care plans had been completed to include residents' preferences regarding their preferred setting. In the sample of care plans reviewed a preference by a resident in shared room to avail of a single room was stated. However, the likelihood of a single room being available in a suitable location was limited and had not been given due consideration by management. The person in charge and operations manager agreed to review this.

Arrangements were described and recorded to demonstrate regular medical and medicine reviews. However, improvements in relation to medicine management were required based on the findings from this inspection.

There was a written operational policy that included the prescribing and administration of medicines to residents. However, the policy had not been implemented in practice and did not meet with professional or regulatory requirements. As a result, residents were not sufficiently protected by medicine management practices and procedures adopted by staff. For example, medicines were administered from a photocopy record dated September 2018, medicines administered did not have a signature of the prescriber, prescription records and kardexs were not sufficiently detailed to identify individual residents.

**Judgment:**

Non Compliant - Moderate

***Outcome 02: Safeguarding and Safety***

**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:**

The self-assessment tool (SAT) completed by the provider for this outcome was rated compliant and the response included continuing to promote a restraint free environment and completion of new quality monitoring audits.

There were measures in place to protect residents from being harmed or suffering abuse, and to promote resident's safety. The centre's safeguarding policy was comprehensive and guided staff on the prevention, detection and response to abuse of

residents. Staff spoken with were clear on what actions to be taken if they observed, suspected or had abuse reported to them. Training records confirmed many staff had received training in how to safeguard residents, with the most recent training occurring in September 2018. However, training gaps for a number of staff existed.

A policy on 'Responding to and managing behaviours that are subject to fluctuate' was available that detailed training was limited to nursing staff. However, other health care staff were observed responding to and required to manage responsive behaviour.

In the morning and afternoon of the inspection, residents with dementia and those with responsive behaviour were being effectively supported by staff. However, this support was inconsistent in the evening and at other times when needed. Residents with behavioural and psychological signs and symptoms of dementia (BPSD) were not consistently provided with timely and appropriate support. Resident behaviour escalated and staff interactions observed did not demonstrate that they had up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that was challenging. A suitable care plan was not in place to guide staff to support each resident needs. The assessment of the behaviour and subsequent record failed to capture the potential or actual antecedents for the behaviour (in accordance with the centre's policy) to inform those analysing or reviewing the associated triggers and factors. Similar findings were reported on the previous inspection and had not been sufficiently addressed.

The person in charge told the inspector of planned training to be provided 21 and 22 November 2018 for all staff involved in the delivery of direct care and support to residents BPSD.

The person in charge and staff team were committed to implementing the national policy 'towards a restraint free environment', and overall the use of restrictive practice in the centre was relatively low. There was a policy on restraint use in the centre that set out the procedure to use when considering if a restriction would result in a positive outcome for residents. Where enablers and restrictions were in place there were records of an assessment and decision making process, some but not all included other less restrictive measures trialled. Assessments did not consistently indicate the rationale for the restraint use or if less restrictive alternatives had been trialled. Therefore, improvement was required around the assessment and review of the use of restraint and provision of alternative options in accordance with the policy and care plan.

The person in charge confirmed that the provider was not a pension agent for residents and did not have responsibility for the safekeeping of any residents' money at this time.

**Judgment:**

Non Compliant - Moderate

***Outcome 03: Residents' Rights, Dignity and Consultation***

**Theme:**

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

No actions were required from the previous inspection.

**Findings:**

The self-assessment tool (SAT) was rated compliant in this outcome. The action plan response included completion of resident satisfaction survey, issuing a revised residents guide and providing staff with training on a new communication policy by 30 November 2018.

The ethos of the service promoted the rights for each resident. Each resident's privacy and dignity was respected, including receiving visitors in private. Residents were facilitated to communicate and enabled to exercise choice and control over their life and to maximise their independence. A residents' committee/-forum was facilitated recently and to continue on a regular basis. All residents were given the option to be registered to vote in the centre.

Information in relation to independent advocacy services was available to residents. Residents' independence and autonomy was promoted. In the main, each resident had opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. Some choose to participate in group activities, while others did not, which was respected. Prayer and religious services continued to be an important aspect of daily life and during the day activities available to residents with dementia reflected the capacities and interests of each resident.

At times the communal environment did not support therapeutic or quality interactions for structured periods in the evening to engage residents in meaningful activities in accordance with their interests or capacities, and communication difficulties. The communal environment, noise, stimuli and activity levels challenged residents with dementia. However, these sensitivities had not been realised to ensure suitable and sufficient activities and care plans were in place to direct care in a consistent manner to support those with communication difficulties or behaviours that challenge.

Findings of the formal observation period carried out using a validated observational tool to rate and record at five minute intervals, the quality of interactions between staff and residents in the activity room, dining room and day room evidenced a high rate of positive connective care with six scores of +2 (75%) awarded when staff provided good quality interaction that demonstrated positive connective care which benefitted the majority of residents. However, during one observation period -1 (25%) was awarded in a protective and controlling approach to care provided from evening observations in the main communal area.

An activity co-ordinator was rostered and on duty weekly to provide recreation and activities for residents. Group activities were offered such as exercises, board games, music sessions, art and crafts, reading, knitting and lotto. In addition to activities held in the centre, outings were organised to local events and areas of interest during the year. There was evidence that such outings had been chosen in collaboration with residents,

and that residents were satisfied with activities that were arranged. Religious ceremonies and a daily mass service formed part of the activity programme.

Residents had access to the hairdresser who came to the centre on a weekly basis and was present on the first day. Residents were seen to be well groomed and dressed in an appropriate manner with clothes and personal effects of their choosing. Residents who spoke with the inspector and those who completed satisfaction questionnaires in September 2018 said they were respected, consulted with and well cared for by the staff. Some suggestions were made for follow up by the management and staff team.

There were arrangements onsite for regular laundering of linen and clothing. Some comments were received by the inspector in relation to problems encountered with the identification and safe return of clothes to residents. This was discussed with management and the process of safeguarding resident property was to be reviewed in association with the information outlined within the residents' guide and admission policy.

The activity co-ordinator and some staff created opportunities for one-to-one activities, for residents who were unable or unwilling to participate in groups. A key to me record that contained relevant information about a resident's life history, hobbies and preferences was available for many residents to inform the planning of activities and conversations. The inspector found that valuable information for staff to reminisce and engage in a person-centred way with residents was gathered and known by most staff but not sufficiently translated in to a relevant care plan to inform all staff and aid reviews of support and care provided.

Residents who spoke with the inspector said they were able to make decisions about their care and had choices about how they spent their day, when and where they ate meals, and when they rise from and return to bed. Residents had options to meet visitors in a private or communal areas based on their assessed needs. The inspector established from speaking with residents, visitors and staff that opportunities to maintain personal relationships with family and friends in the wider community was encouraged. Visitors were unrestricted except in circumstances such as an outbreak of infection. A record of visitors was maintained. Arrangements were provided for residents to attend external appointments or family occasions and maintain links with the religious or wider community. The centre had transport arrangements for residents to access to the wider community. Overall, the arrangements in place promoted social inclusion, engagement and access to external facilities.

The communication policy received had been authorised by the person in charge and registered provider representative and was issued in March 2015 and reviewed in September 2016. It was due to be reviewed next in August 2019. This policy was comprehensive and included relevant information to promote good communication with residents and relevant others. It provided staff with a 'quick reference guide' and information in relation to the assessment and care planning protocols for communication.

Arrangements for residents to be consulted with and participate in the organisation of the centre on a day-to-day basis were described and evidenced. Staff were allocated to

care and support a number of residents on a daily basis. Staff knew residents and their relatives well, and residents were familiar with the person in charge and staff members.

There were notice boards available throughout the centre providing information to residents and visitors. Radio, television, wifi and newspapers were available for information about current affairs and local matters.

**Judgment:**  
Substantially Compliant

#### *Outcome 04: Complaints procedures*

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

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

**Findings:**  
A complaints process was in place to ensure the complaints of residents including those with dementia were managed.

The complaints procedure was prominently displayed in the reception area and was summarised in the residents guide and statement of purpose, to be reviewed. The process included an appeals procedure and contacts details of the ombudsperson.

The complaints procedure met the regulatory requirements.

Residents who met the inspector were clear about who they would bring a complaint to. Any information from concerns and complaints were to form part of the quality improvement process.

The Inspector was shown one written complaint received this year which had been logged and managed promptly using the complaints process. Records showed the outcome and satisfaction level of the complainant.

**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:**

The appropriateness of staff numbers and skill mix required review to ensure they met the assessed needs of residents, and in particular residents with a dementia and those with communication needs and behaviours that fluctuate.

A recruitment policy in line with the requirements of the regulations was implemented in practice. The inspector examined a sample of staff files and found that all were complete. The inspector saw that a list was in place to ensure that all staff files included the requirements of the Regulations. Garda Clearance was present in the staff files reviewed and person in charge and operations manager confirmed that all staff were Garda Vetted prior to commencement.

An actual and planned roster was maintained in the centre with any changes clearly indicated. The inspector reviewed the roster which reflected the staff on duty. Residents who spoke with the inspector were complimentary of the staff and the care provided. Staff and residents were satisfied that there were adequate staff numbers on duty over a 24 hour period and at weekends, but deficiencies on occasions in the replacing of staff when on unplanned leave was reported. The departure of key staff had been a recent occurrence. The recruitment of staff to replace these positions had not yet been complete; as a result, a limited number and fulltime staff existed. Reliance on relief, part-time and bank staff was required. The staffing arrangements and provision had not ensured consistent care or adequate communication, recording and implementation of agreed policies.

Arrangements were in place to train, supervise and appraise staff. A Training Matrix was available, however, gaps in staff training (mandatory and relevant) were found in areas such as safeguarding, manual handling, fire safety, dementia and behaviours that challenge. Other training deficits in relation to medicine management, cardio pulmonary resuscitation, wound management and clinical recording (assessment and care plans) was evident.

The person in charge told the inspector that volunteers were not engaged by the centre.

**Judgment:**

Non-Compliant - Moderate

***Outcome 06: Safe and Suitable Premises*****Theme:**

Effective care and support

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

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

**Findings:**

The single story purpose built nursing home is situated on an elevated site overlooking Lough Swilly.

The location, design and layout of the centre were suitable for its stated purpose and met residents' individual and collective needs in a comfortable and homely manner. The inspector found the centre to be calm, welcoming, warm, well ventilated and reasonably well maintained and decorated throughout. Residents and staff told the inspector that the reception area, corridors and room doors had been painted recently. Bedroom doors were painted in three striking colours as were the bathroom facilities opposite the main day rooms. A refurbishment plan to include painting and the replacement of wardrobes and bedroom furniture was described with tenders issued.

The dining room adjoined the kitchen where meals were prepared onsite. There was ample communal space including three adjoining day rooms as the main communal area, an activity room, a quiet room (not currently in use), a separate sitting room next to the main rooms and a kitchenette where breakfast was served from.

There was a large chapel, offices, store rooms, bathrooms, a smoking room, staff rooms and a hairdressing salon on site. Residents had access to a variety of outdoor areas including a secure well maintained garden courtyard.

Corridors and door entrances used by residents were wide and spacious to facilitate movement and aids used and required by residents. The flooring throughout was safe and adequate. There were plenty of seating options where residents congregated. Handrails and grab rails were provided where required in circulating areas and in bathrooms. The provision of contrasting colours, landmarks and appropriate signage to support way-finding was to be considered in the refurbishment programme.

Bedroom accommodation was provided with 18 single and 15 double/twin bedrooms. Many had en-suite facilities. All bedrooms had a call bell and telephone and some of the residents had clocks and calendars in their bedrooms along with other personal mementoes. Residents had a locked facility in their rooms.

Bedrooms were spacious enough to accommodate personal equipment and devices required by existing residents, many bedrooms were personalised to suit the individual resident, however, the positioning on beds observed in some of the shared rooms required review and improvement.

While staff had made some progress towards creating a dementia friendly environment and this was apparent on the inspection. Further enhancements to optimise functioning and support way finding for those with dementia were required.

Measures had been taken to control the environment, but factors such as noise level heard from the trolley used to deliver stock to the kitchenette from the main kitchen in the mornings required review. In addition, some residents reported dissatisfaction about the noise levels at night.

**Judgment:**  
Substantially Compliant

***Outcome 08: Governance and Management***

**Theme:**  
Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

As a result of the findings of inspection, the inspector concluded that the registered provider had not ensured that the designated centre had sufficient management systems in place to ensure that the service provided was appropriate, consistent and effectively monitored. For example, a staff training matrix was maintained, however, this audit failed to ensure appropriate oversight, provision and updating of staff training needs.

Suitable and sufficient communication arrangements between all staff was not demonstrated to ensure the effective delivery of care. All staff were not up to date in relation to the necessary care and supports required by residents.

A lack of oversight, systematic monitoring and auditing was apparent and the reporting structures and communication arrangements were not robust. Approved policies had not been implemented in practice. Gaps in the recording, reporting and communication systems were identified.

Clarity in relation to lines of authority and accountability arrangements associated with specific roles within the organisation was required. Changes to those participating in management had occurred and were not yet notified to the Office of the Chief Inspector.

The improvements required following the previous inspection April 2018 had not been fully addressed and some actions are restated within this action plan for response.

**Judgment:**  
Non-Compliant - Moderate

## 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:***

Sonia McCague  
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<sup>1</sup>

<b>Centre name:</b>	Nazareth House
<b>Centre ID:</b>	OSV-0000368
<b>Date of inspection:</b>	16 and 17 /10/2018
<b>Date of response:</b>	15/11/2018

#### 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 (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**

The admission policy was not sufficiently detailed to guide best practice.

##### **1. Action Required:**

Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them

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

in accordance with best practice.

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

The Admission Policy will be reviewed and amended to ensure that best practice is adhered to as set out in Regulation 4(1).

**Proposed Timescale:** 15/11/2018

**Theme:**

Safe care and support

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

Assessments were not comprehensive or completed in full on or following admission of residents.

**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:**

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 will be completed.

**Proposed Timescale:** 28/02/2019

**Theme:**

Safe care and support

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

As residents' needs were identified or changes occurred it did not prompt the development or updating of an appropriate care plan.

The absence of a specific care plan did not aid the evaluation of interventions and treatments prescribed or given.

Gaps in the care planning and review process were evident and assessments carried out by allied health care professionals had not been referenced or reflected within existing care plans to guide staff and ensure the agreed best practice.

**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:**

Care Plans will be prepared, 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.

Gaps in the care planning and review process identified during the inspection, will be reviewed and rectified by allied health care professionals ensuring that the care plans help to guide staff and ensure the agreed best practice.

**Proposed Timescale:** 30/03/2019

**Theme:**

Safe care and support

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

Improvements in relation to medicine management were required to comply with professional standards and the centre's policy.

Residents were not sufficiently protected by medicine management practices and procedures adopted by staff. For example, medicines were administered from a photocopy record dated September 2018, medicines administered did not have a signature of the prescriber, prescription records and kardexs were not sufficiently detailed to identify individual residents.

**4. 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:**

In order to 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, a review of all medicine management practices and procedures adopted by staff will be carried out with the multi-disciplinary team. All associated records will be reviewed and improved to meet best practice and professional guidelines. Training arranged for nursing staff will be carried out during November and December 2018.

**Proposed Timescale:** 28/02/2019

**Theme:**

Safe care and support

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

The likelihood of a single room being available in a suitable location was limited and had not been given due consideration by management.

**5. Action Required:**

Under Regulation 13(1)(d) you are required to: Where the resident approaching end of life indicates a preference as to his or her location (for example a preference to return home or for a private room), facilitate such preference in so far as is reasonably practicable.

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

A dedicated single room for residents who require 'end of life' care will be created as far as it is reasonably practicable. A review of the facility will be conducted in first half of 2019.

**Proposed Timescale:** 31/12/2019

**Theme:**

Safe care and support

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

Significant improvement was required in relation to the assessment, recording, reporting and care planning processes due to the gaps identified and reported to staff.

Delays were encountered in accessing resident information and clinical records.

**6. 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 set out in Schedules 2, 3 and 4 under Regulation 21(1) are kept in the designated centre and are available for inspection by the Chief Inspector. Training for nurses on the IT Care Plan system took place in October and a further training day is planned in November for staff. The organisation has a central support system available to staff in the centre which will result in improvement in relation to assessment, recording and reporting.

**Proposed Timescale:** 31/01/2019

**Outcome 02: Safeguarding and Safety**

**Theme:**

Safe care and support

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

A policy on 'Responding to and managing behaviours that are subject to fluctuate' was available that detailed training was limited to nursing staff. However, other health care staff were observed responding to and required to manage responsive behaviour.

**7. Action Required:**

Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

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

The policy on 'Responding to and managing behaviours that are subject to fluctuate' has been reviewed and updated to include detailed training to all health care staff. Training for nursing and healthcare staff will be completed during December 2018 and January 2019.

**Proposed Timescale:** 31/01/2019

**Theme:**

Safe care and support

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

Some staff interactions observed did not demonstrate that they had up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that was challenging.

The assessment of resident behaviours failed to capture the potential or actual antecedents for the behaviour (as outlined in the centre's policy) to inform those analysing or reviewing the associated triggers and factors.

**8. Action Required:**

Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

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

Training will be provided to nursing and healthcare staff to update their knowledge and skills appropriate to their role in order to respond and manage behaviour that is challenging. Training for nursing and healthcare staff will be completed during December 2018 and January 2019. Policy review sessions will be conducted throughout the year during staff meetings.

The assessments of resident behaviours will be reviewed and updated to capture the

potential or actual antecedents for the behaviour to inform those analysing or reviewing the associated triggers and factors.

**Proposed Timescale:** 28/02/2019

**Theme:**

Safe care and support

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

Some assessments did not consistently indicate the rationale for the restraint use or if less restrictive alternatives had been trialled.

**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:**

All assessments will be reviewed and amended to indicate the rationale for the restraint use or if less restrictive alternatives can be trialled, where applicable and only in accordance with national policy.

**Proposed Timescale:** 30/11/2018

**Theme:**

Safe care and support

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

A suitable record or care plan was not in place to guide staff to support each resident needs.

**10. 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:**

All care plans will be reviewed and amended to ensure a suitable record or care plan is in place to guide staff to support each resident needs as set out under Schedules 2, 3 and 4.

Issues in relation to care plans and resident records have now been addressed and will be updated to be more person centred and will be reviewed formally as required by the residents changing needs or circumstances to include all the essential information. The care plans will be reviewed and updated after consultation/discussion with the resident / next of kin for agreement.

**Proposed Timescale:** 28/04/2019

### **Outcome 03: Residents' Rights, Dignity and Consultation**

**Theme:**

Person-centred care and support

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

At times the communal environment did not support therapeutic or quality interactions for structured periods in the evening to engage residents in meaningful activities in accordance with their interests or capacities, and communication difficulties.

**11. Action Required:**

Under Regulation 10(1) you are required to: Ensure that each resident, who has communication difficulties may communicate freely, having regard to his or her wellbeing, safety and health and that of other residents in the designated centre.

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

A review will be completed of the communal environment and altered where required to support therapeutic or quality interactions for structured periods in the evening to engage residents in meaningful activities in accordance with their interests or capacities, and communication difficulties.

**Proposed Timescale:** 30/04/2019

**Theme:**

Person-centred care and support

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

The communal environment, noise, stimuli and activity levels challenged residents with dementia. However, these sensitivities had not been realised to ensure suitable and sufficient activities and care plans were in place to direct care in a consistent manner to support those with communication difficulties or behaviours that challenge.

**12. Action Required:**

Under Regulation 10(2) you are required to: Where a resident has specialist communication requirements record such requirements in the resident's care plan prepared under Regulation 5.

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

The communal environment will be reviewed and improved to take into consideration noise, stimuli and activity levels that may challenge residents with dementia. As part of this review consideration will be given to ensuring that suitable and sufficient activities and care plans are in place to direct care in a consistent manner to support those with

communication difficulties or behaviours that challenge.

**Proposed Timescale:** 30/04/2019

**Theme:**

Person-centred care and support

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

Problems had been encountered with the identification and safe return of clothes to residents.

**13. 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:**

A new labelling system and identification of clothing will be implemented.

**Proposed Timescale:** 31/03/2019

#### **Outcome 05: Suitable Staffing**

**Theme:**

Workforce

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

The appropriateness of staff numbers and skill mix required review to ensure they met the assessed needs of residents, and in particular residents with a dementia and those with communication needs and behaviours that fluctuate.

**14. 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:**

A review has been completed of staff numbers and skill mix to ensure they meet the assessed needs of residents, and in particular residents with a dementia and those with communication needs and behaviours that fluctuate.

**Proposed Timescale:** 09/11/2018

**Theme:**

Workforce

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

Gaps in staff training (mandatory and relevant) were found in areas such as safeguarding, manual handling, fire safety, dementia, communication and behaviours that challenge.

Other training deficits in relation to medicine management, cardio pulmonary resuscitation, wound management and clinical recording (assessment and care plans) was evident.

**15. Action Required:**

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

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

A training analysis has been completed for all staff identifying the gaps. Training commenced in November to address these gaps and the outstanding training will be carried out in December, January, February and March 2019.

**Proposed Timescale:** 31/03/2019

**Theme:**

Workforce

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

The staffing arrangements and provision had not ensured consistent care or adequate communication, recording and implementation of agreed policies.

**16. 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:**

A review has been completed of staffing arrangements and relevant training has been scheduled to ensure they meet the assessed needs of residents, and in particular focusing on consistent care or adequate communication, recording and implementation of agreed policies and is appropriately supervised.

**Proposed Timescale:** 30/03/2019

**Outcome 06: Safe and Suitable Premises**

**Theme:**

Effective care and support

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

The positioning of beds observed in some of the shared rooms required review and improvement.

A refurbishment plan to include painting and the replacement of wardrobes and bedroom furniture was to commence.

The provision of contrasting colours, landmarks and appropriate signage to support way-finding was to be considered in the refurbishment programme.

The noise levels during the day, evening and night required review.

**17. 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 refurbishment plan to include painting and the replacement of wardrobes and bedroom furniture has commenced.

The provision of contrasting colours, landmarks and appropriate signage to support way finding will be considered in the refurbishment programme.

The noise levels during the day, evening and night will be reviewed and any actions identified will be implemented.

The positioning of beds in some of the shared rooms will be reviewed and changed where practicable.

**Proposed Timescale:** 31/03/2019

**Outcome 08: Governance and Management**

**Theme:**

Governance, Leadership and Management

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

Clarity in relation to lines of authority and accountability arrangements associated with specific roles within the organisation was required.

**18. Action Required:**

Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

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

Clarity in relation to lines of authority and accountability arrangements associated with specific roles within the organisation will be developed clearly defining the management structure, lines of authority and accountability.

**Proposed Timescale:** 31/01/2019

**Theme:**

Governance, Leadership and Management

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

As a result of the findings of inspection, the inspector concluded that the registered provider had not ensured that the designated centre had sufficient management systems in place to ensure that the service provided was appropriate, consistent and effectively monitored. The staff training matrix/audit failed to ensure appropriate provision and updating of staff training needs.

Suitable and sufficient communication arrangements between all staff was not demonstrated to ensure the effective delivery of care. All staff were not up to date in relation to the necessary care and supports required by residents.

A lack of oversight, systematic monitoring and auditing was apparent and the reporting structures and communication arrangements were not robust. Approved policies had not been implemented in practice. Gaps in the recording, reporting and communication systems were identified.

The improvements required following the previous inspection April 2018 had not been fully addressed and some actions are restated for response.

**19. Action Required:**

Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

The Registered Provider will review all management systems and put in place systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

**Proposed Timescale:** 28/02/2019