

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Nazareth House
Centre ID:	OSV-0000149
Centre address:	Malahide Road, Clontarf, Dublin 3.
Telephone number:	01 833 8205
Email address:	maura.hooper@nazarethcare.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Sisters of Nazareth
Provider Nominee:	Maura Hooper
Lead inspector:	Nuala Rafferty
Support inspector(s):	Sheila McKeivitt
Type of inspection	Announced
Number of residents on the date of inspection:	87
Number of vacancies on the date of inspection:	0

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 decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
29 June 2016 09:30	29 June 2016 19:30
30 June 2016 09:30	30 June 2016 17:00

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Substantially Compliant
Outcome 03: Information for residents	Substantially Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Compliant
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 10: Notification of Incidents	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 13: Complaints procedures	Compliant
Outcome 14: End of Life Care	Compliant
Outcome 15: Food and Nutrition	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 17: Residents' clothing and personal property and possessions	Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This was an announced inspection and formed part of the assessment of the application for renewal of registration by the provider. The inspection took place over two days and as part of the inspection, practices were observed and relevant documentation reviewed such as care plans, medical records, accident logs, policies and procedures and staff files. The views of residents, relatives and staff members of

the centre were also sought.

As part of the application for renewal of registration, the provider was requested to submit relevant documentation to the Health Information and Quality Authority (HIQA). All documents submitted by the provider, for the purposes of application to register were found to be satisfactory. The fitness of the nominated person on behalf of the provider and the person in charge were assessed through an ongoing fit person process. They demonstrated knowledge 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 throughout the inspection process.

Information in the form of notifications and other information brought to the attention of the Authority were also considered as part of the inspection process.

Recent changes to the clinical management team within the centre were found on this inspection with an assistant director of nursing and a number of clinical nurse managers commencing in post in recent months. Through the inspection process the assistant director of nursing, who is nominated to replace the person in charge if absent, demonstrated satisfactory knowledge of their role and responsibilities and sufficient experience and knowledge as required by the legislation.

A number of resident's and relatives' questionnaires were given to the inspectors during the inspection. The opinions expressed through the questionnaires were broadly satisfactory with services and facilities provided. In particular, they were very complimentary on the manner in which staff delivered care to them commenting on their patience, good humour and respectful attitude.

Overall, evidence was found that residents' healthcare needs were met. Residents had access to medical officers and consultant geriatrician services within the centre. Access to allied health professionals such as physiotherapy, speech and language therapists and to community health services were also available.

However, improvements were found to be required including staff training, documentation and the assessment, planning and recording of care.

The Action Plan at the end of this report identifies areas where improvements are required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated 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:

A written statement of purpose was available that broadly described the service provided in the centre and contained all of the information required by Schedule 1 of the Regulations.

Copies of the document were available in the centre

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):

No actions were required from the previous inspection.

Findings:

Evidence was found that there were sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose. A clearly defined management structure that identified the lines of authority and accountability was also in place. The registered provider is an international religious order with an overarching governance

structure that included corporate, financial and administrative personnel. A Regional and National Secretariat and Executive staff provide supports to the operational management team within the centre.

The provider nominee is the general manager in the centre who works closely with the person in charge and a clinical team.

Governance systems were found to have improved on this inspection. The provider and the person in charge (PIC) had commenced implementing many of the actions contained in their response to the actions arising from the previous inspection.

An improved level of supervision and support to frontline nursing and care staff was in place. A clinical management team had been established further to the last inspection. The team consisted of an assistant director of nursing (ADON) and an additional 1.5 whole time equivalent clinical nurse managers(CNM). This gave a total of 3.5 fulltime CNM's and one full time ADON. Inspectors noted that the provision of a consistent and full time CNM presence had led to better standards of nursing care and improvements to culture and practice.

Systems in place to monitor had been established and data was being collated on a monthly basis on key performance indicators(KPI's) of clinical care such as; falls; pressure ulcers; medication errors and nutrition management.

A Clinical Governance Committee commenced weekly meetings in September 2015 to discuss both clinical and non clinical risks. Recurrent agenda items included; health & safety; risk management; maintenance; recruitment; staffing and infection prevention and control. It also reviewed the data collated on the KPI's. Inspectors read a sample of the weekly committee meetings minutes.

The minutes of the governance committee were brief and analysis of audits and learning or improvements to initiate practice changes were not documented. The information in the minutes did not indicate a full analysis of the KPI's had taken place, identify any actions or measures undertaken, learning derived or review to be conducted. Although the management team were collecting information on clinical care indicators the process was not yet complete. A quality assurance programme to continuously review and monitor the quality and safety of care was not fully established through a complete audit cycle. Some of the audits viewed included some learning and actions required to improve practice although they did not always include the actions taken to address the problem identified, when the action was implemented or reviewed to determine effectiveness.

In particular it was noted that where medication errors were reported, evidence that measures identified to reduce or prevent recurrence were implemented was not always available. Evidence that measures were implemented and were reviewed by the Governance committee or PIC to evaluate the safety of medication administration within the centre was not available. External auditors were engaged to review practices in a number of areas in September 2015. These included; care planning assessment and recording and pressure area care. Findings of the external auditors were replicated on this inspection in relation to fragmentation of records and incomplete assessment. Full findings on these areas are reported under the relevant outcomes. But it was noted that recommendations of the auditors had not yet been fully implemented, although inspectors accept that work had been progressed in several areas.

As previously stated improvements to the standard of care delivered to residents were found and risks identified on previous inspections were mitigated. But inspectors found

that these improvements were predominantly due to increases to the level of nursing staff at CNM level. Further improvements in governance were required to improve the level of care monitoring and to develop competence and skills in nursing and care teams in order to meet the future needs of the service.

This was discussed at length throughout the inspection with the senior management team including the provider nominee and regional executive officer. The registered provider is currently in the process of developing the service with a view to increasing capacity. Team development through performance appraisals; skill development and training to meet the needs of the current and future resident profile was required. Inspectors found that skill development was also required by the senior management team. Through the inspection process, all demonstrated satisfactory knowledge of their role and responsibilities and sufficient experience and knowledge as required by the legislation. But it was also noted that none of the current team had a Gerontology or Dementia specific qualification and there was little experience of and no specific qualification within the team, in leadership skills, auditing or analysis in order to drive improvements through learning. Only one team member had a higher level Management qualification.

An annual review of safety and quality of care was also in place. A report on the review was available. The report although not detailed, identified the key performance indicators such as; staff recruitment, retention and training; complaints analysis and service developments. Other quality care indicators were referenced to indicate the standard of and safety and quality of service being delivered.

Judgment:

Substantially Compliant

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:

Each resident had an agreed written contract which deals with the resident's care and welfare. The contract included all details of the services to be provided for that resident and the fees to be charged.

This included a list of facilities and services provided including laundry, meals, and housekeeping. Services offered in the centre which incurred additional fees were listed. Additional fees for activities were identified but the contract did not include an opt out clause for these charges for those residents not wishing to avail of activities provided. A guide to the centre was available to all residents. This described the centre services, management, complaints procedure, and contact information for useful external bodies.

Communal areas such as the lobby also had information on display regarding the complaints procedure, evacuation instructions, detail's of staff on duty and contact details for advocacy services.

Judgment:
Substantially Compliant

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 centre was managed by a qualified and experienced nurse as required by the legislation. The person in charge held authority, accountability and responsibility for the provision of the service.

Through an assessment process it was noted that there was daily engagement in the governance, operational management and administration of the centre. The person in charge facilitated the inspection process by providing documents and having good knowledge of residents' care and conditions.

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:

Records set out in Part 6 of the Regulations were available and kept in a secure place. The Statement of Purpose and Residents' Guide were complete and available. A copy of the insurance cover in place was provided which meets the requirements of the Regulations were displayed in the reception area.

The directory of residents was reviewed and was found to meet the requirements of the Regulations and was up to date with records of admissions discharges and transfers maintained.

Although not all records were reviewed on this visit, it was found that, overall, general records as required under Schedule 4 of the Regulations were maintained including key records such as appropriate staff rosters, accident and incidents, nursing and medical records. Planned rosters were in place in all units and an actual working rota was maintained. All of the operational policies and procedures as required by Schedule 5 of the Regulations were available and were reviewed on a regular basis and within the three year timeframe as required by the regulations.

But some policies in place were not detailed enough to adequately guide staff and ensure the safety of residents in the centre.

Inspectors found that policies and procedures in place to manage risks associated with missing residents and evacuation of the centre in the event of an emergency did not include all the information required for staff to respond effectively. For example the policy and procedure for responding to a missing resident did not include specific parameters for the search within the building, grounds or extended off the centre premises; use, location or availability of equipment or the requirement for a vehicle, driver or assistant to be available to recover a missing resident.

Personal evacuation plans were in place but did not identify the level of cognitive understanding, need for supervision or level of compliance of each resident in an emergency situation.

The management team facilitated the inspection by making all documents and records available and assisted the inspection team by locating documents or records where required during the process. But it was noted that the record system in place to create, store and locate records required to be reviewed as records were not easily located or retrieved. There were several folders that contained similar types of records or documents and this led to duplication of effort .Fragmentation of records also made access, retrieval and ease of use difficult for all concerned.

Judgment:

Non Compliant - Moderate

***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.***

<p>Theme: Governance, Leadership and Management</p>
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: Suitable arrangements were in place for periods of absence of the person in charge and the provider complied with his responsibilities to notify the Authority when a change occurred to both the person in charge and the nominated person to replace them. The fitness of the assistant director's of nursing to replace the person in charge in the event of her absence was determined through observation and discussion during the inspection and had the qualifications and experience required by the legislation.</p>
<p>Judgment: Compliant</p>

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:
A review of the use of restraint found that there was a reduction in the use of bed rails throughout the centre although bed rails were still in place for some residents. The use of bed rails and lap belts was reduced. A culture of promoting a restraint free environment with an increase in the use of alternative safety measures such as bed alarms, roll out mats and low- low beds was being established. Evidence of alternatives considered or trialed was available and a clear rationale for use of a small number of bed rails was referenced in risk assessments or in associated care plans. Staff had been provided with training on the prevention of elder abuse, although it was noted that all staff had not attended training provided. All staff spoken too were clear on their role and responsibilities in relation to reporting abuse. Staff were also knowledgeable in recognising the possible signs and symptoms, responding to and managing abuse.

Procedures to protect residents, such as a robust recruitment system, staff induction

and training were also in place and implemented.

In conversations with them, inspectors were told by residents that they felt safe and secure in the centre and relatives also confirmed that they did not have any concerns for the safety of their loved ones.

It was noted that the centre policy on prevention of elder abuse was updated to reflect the most recent HSE guidance on safeguarding vulnerable adults.

The inspectors reviewed the system in place to manage residents' money and found that reasonable measures were in place and implemented to ensure resident's finances were fully safeguarded. The provider assisted residents to manage small sums of money in comfort funds and stated they were not involved in the management of pensions through private property accounts.

Judgment:

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):

No actions were required from the previous inspection.

Findings:

Emergency lighting and fire fighting equipment, directional signage and appropriate fire procedures were available throughout the building.

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 available. A CCTV system was in place externally.

The centre was found to be visibly clean and clutter free.

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. A composite list of all residents that identified their level of mobility and assistance required to evacuate was available, but this did not include their possible compliance with an evacuation process or whether close supervision was needed following evacuation.

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. Inspectors were told regular fire drills were held which included activation of the fire alarm, staff responded by checking the fire panel located at the main reception. All staff were familiar with the principles of horizontal evacuation but inspectors learned that the practiced fire drills. These drills also included simulation of an actual evacuation to determine the

competency of staff to use evacuation equipment such as evacuation sheets and practicing the principles of vertical evacuation. However, in conversation with them some residents said that when the fire alarms were activated that they were not included in the evacuation process or informed on what was going on or what they should do. These residents said that this was a cause of anxiety to them and that although they knew staff were responding to the fire alarm it would be a great relief if they could be included, for example told where the assembly point was, or explained what the fire procedure and evacuation plan was so that they would know what to expect, how to react and where to go.

Appropriate arrangements for investigating and learning from serious incidents/adverse events which identified residents who were at risk of falls and put in place appropriate measures to minimise and manage the risks was in place. A risk register was established which was regularly reviewed and updated. There were arrangements in place to review accidents and incidents within the centre, and residents who had fallen had falls risk assessments completed after the falls and care plans were updated.

Governance and supervision systems were in place to monitor residents at risk of falls, wandering or negative interactions. These were reviewed on an ongoing basis. good supervision systems were in place in communal areas.

Inspectors observed that staff implemented the principles of current Moving & Handling guidance when assisting residents to transfer.

Systems to support staff knowledge and implementation of best practice to ensure good infection prevention and control were in place. Staff spoken to were confident in their knowledge of the procedures in place, recognised the importance of their role in meeting resident's healthcare needs and were observed to implement good practice.

Judgment:

Compliant

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):

Findings:

Inspectors found that there were written operational policies in place in the centre relating to the ordering, prescribing, storage, and administration of medicines to residents.

Medicines were supplied to the centre by a retail pharmacy business in a monitored dosage system that consisted of blister packed medication. Medicines were stored securely in the centre in medication trolleys or within locked storage cupboards. A

secure fridge was available to store all medicines and prescribed nutritional supplements that required refrigeration, and temperatures were checked and recorded on a daily basis. Controlled drugs were stored securely within a locked metal cabinet, and balances of all controlled drugs were recorded in the controlled drugs register. Nursing staff checked and documented the balances of all controlled drugs twice daily at the change of shift. Nursing staff were familiar with the procedure for disposing of unused or out of date medicines.

Inspectors observed nursing staff administering medicines to residents during the evening administration rounds on one of the units. The nurse knew the residents well, and was familiar with the residents' individual medication requirements. Inspectors observed that the nurses took time to ensure each resident was comfortable before administering their prescribed medicines in a person centred manner. Nurses were observed to use alcohol hand gels appropriately throughout the process. Medication administration practices were found to adhere to current professional guidelines.

Medication audits were conducted in the centre and inspectors reviewed a sample. It was noted that these audits were conducted by the external pharmacist and did not include nursing or medical inputs. These audits only covered some aspects of good medication management practices. The audits were conducted on a regular basis by the external pharmacist who supplied medicines to the centre. The audits looked at aspects such as; storage, labelling, administration records controlled medicines and temperature controls on medicine refrigeration.

Medication errors were appropriately recorded. Although action plans associated with follow up on these medication errors included appropriate feedback to staff, it was not always evident that the actions were implemented or reviewed for effectiveness.

Improvements to prescribing practices required following the last inspection were implemented including identification of maximum dosage and guidance to staff on administration of PRN or as prescribed medicines; photographs of residents to aid recognition and medicines suitable for crushing.

It was noted however, that the duration of medication administration was outside recommended guidance for early morning medicines at specific times. There were several reasons for this including respecting resident's choice for waking and attending religious services. This was discussed with the management team and measures to address this including review of the times for administration were required.

Judgment:

Non Compliant - Moderate

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:

A record of all incidents occurring in the designated centre was maintained. But a small number of relevant incidents were not notified to the Chief Inspector as required under Regulation 31.

Judgment:

Non Compliant - Moderate

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.

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:

Access to medical and allied health professionals was available. Residents had access to a general practitioner (GP)

Evidence of access to allied health professionals was also found with documented visits, assessments and recommendations by occupational therapy, physiotherapy and psychiatry dental, optical and podiatry services. Access to palliative care specialists was available through the primary care and acute hospital services. Increased access to a dietician consultancy service was found to be provided.

Improvements to the standard of care provided was found on this inspection with more timely responsiveness and referral to allied health professionals to manage risks associated with deteriorating clinical needs. These included improvements to the management of risks associated with; nutrition, pressure ulcers, falls and responsive behaviours.

A new system was being implemented to improve processes in place for the assessment planning implementation and review of healthcare needs. This involved a move from paper based systems to a computerised system. Although it is acknowledged that the new system was not yet fully operational and staff were in the process of transferring all information on to the computer data base it was noted that some further improvements were found to be required. Improvements included care plans and assessments for nutrition and pressure ulcer care. These referenced recommendations of allied health professionals, frequency of weight monitoring and monitoring of intake. Wound care

plans referenced the need for pain relief.

Further improvements required included; comprehensive risk assessments of daily living were not fully completed. Some healthcare plans in place they did not contain enough detail to ensure they were effectively managing the health problem such as positive behaviour support plans did not include the form the behaviours might take, triggers associated with the behaviour, distraction or de escalation techniques to manage the behaviours. Care plans for end of life care and falls management were not specific enough to fully guide care. Where end of life care plans were in place they referenced residents preferences and needs but the clinical management of the care needs were not included and other care plans that formed part of the management of these needs were not referenced. Also, although it was noted that these plans were reviewed on a quarterly basis. The reviews did not include a determination of effectiveness to ensure improvement in the standard of care being delivered.

Judgment:

Non Compliant - Moderate

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):

Findings:

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

The extended centre is now over three floors ground, first and second level.

Residents of the centre only reside on the ground and first floors.

There is a large sunny foyer on the ground floor with comfortable seating coffee dock residents shop and access to an enclosed accessible garden with walkways and seated areas.

The first floor extension comprised of 15 bedrooms with full en-suite, a computer room, sluice, nurses' station, medical storage rooms and assisted bath room and is accessed by both stairs and lift from the ground floor. This meets the requirements of the

regulations.

However, during the last registration inspection the physical environment of the original building was found to pose challenges to meet residents' needs safely and improvements to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland improvements were required by 2015.

Findings on this registration inspection replicate the findings of the inspection in 2013 in that, aspects of the design and layout of the centre was not suitable for its stated purpose and did not meet residents needs in a safe and comfortable way.

In summary the main environmental challenges relate to;

-design and layout of the bedrooms with shared 'en-suite facilities' do not meet residents needs for privacy, dignity and access to appropriate toilet or washing facilities. They did not allow safe access to residents using assistive moving and handling equipment or allow staff to provide safe assistance to residents with low dependency needs.

- 13 bedrooms did not meet the requirements of the legislation in terms of usable space for residents.

- insufficient number of appropriately located wheelchair accessible toilets and shower/bath facilities in the centre.

- insufficient number and inappropriate location of sluice facilities.

- ramped areas of the internal centre were steep and posed problems for both staff and residents in terms of access and safety.

However, the provider forwarded a plan that addresses the deficiencies of the premises. This involves a separate building development on the grounds of the existing centre and is currently underway.

A health & safety plan to appropriately and safely manage risks associated with the new build were also provided and these were found to be fully implemented during the inspection process. All the requirements of relevant building legislation have been adhered to and evidence was available that planning permission was granted and fire safety certification of the new build was in progress.

The proposed completion of phase 1 of the new development is scheduled for June 2017 with completion of Phase 2 by December 2017

The existing premises were noted to be maintained to a good standard and evidence of ongoing maintenance, such as painting and repairs to the fabric of the building was found. In general the building was found to be clean and walkways were free of clutter. Signage and cueing within the centre needed to improve to support freedom of movement for residents with dementia.

Picture and colour cueing was not found and the function of all rooms within the centre was not identified.

But ramped area had not yet been reviewed to determine whether they were safe for use by residents using mobility aids. Identification of the ramp as a potential hazard was not in place.

Judgment:

Non Compliant - Moderate

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:

Policies and procedures which comply with legislative requirements were in place for the management of complaints. Residents were aware of the process which was displayed. However the policy inappropriately referenced HIQA as part of the complaints process. The provider agreed to amend the policy to remove this reference.

On review of the record of complaints there was evidence that all complaints were documented, investigated and outcomes recorded. Complainants were notified of the outcomes and a review was conducted to ascertain the satisfaction of the complainant further to issues being resolved.

Although nominated persons were in place to ensure the process was adhered too. It was noted that some persons were allocated responsibilities that were not fully in accordance with the regulation. The provider will review the roles to address this issue.

Judgment:

Compliant

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:

A small number of residents were receiving 'end of life' or 'comfort care' during this inspection. A sample of documentation reviewed found that there were arrangements in place for capturing residents' end-of-life preferences in relation to issues such as; spiritual needs or preferences for place of death or funeral arrangements.

Although the system in place to capture residents and families preferences and wishes was good, it was not always fully completed.

Although end of life care plans were also in place, they were not sufficiently specific to direct the care to be delivered in a holistic manner. This was previously referenced under Outcome 11 where an action plan is required.

It was noted that residents family and friends could be facilitated and religious and cultural preferences respected as far as practicable. Access to specialist palliative care services were available where appropriate.

Judgment:

Compliant

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):

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

Findings:

Residents were provided with food and drink at times and in quantities adequate for their needs. Assistance was observed and was offered to residents in a discreet, patient and sensitive manner by all staff.

The dining experience was conducive to conversation. Those residents on modified diets were offered the same choices as people receiving normal diets. A rolling menu was in place to offer a variety of meals to residents.

Most residents took their meals in the dining rooms located on each floor in the centre and tables were appropriately set with cutlery condiments and napkins. Residents spoken with all agreed that the food provided was always tasty hot and appetising. Food was served from a hot plate by a team of staff and was well presented. Modified consistency diets were served appropriately with each element of the meal presented in separate portions on the plate. A list of all special diets required by residents was compiled on foot of the individual residents' reviews and copies were displayed in the main kitchen and in the kitchenettes on each unit. Residents nutritional needs were being closely monitored. Those identified with loss of weight or dehydration were seen by the dietician and where required food and fluid intake recording was in place. Updated diet sheets were sent to the catering team. It was noted that the correct diet as recommended by the dietician was provided to each resident.

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 dispensers were available.

Meal times were observed to be an enjoyable experience. Residents could choose where they sat or were enabled by staff to decide.

Many residents had their favourite table and companions with whom they liked to sit. There was a hum of conversation and an atmosphere not unlike that of a well run and pleasant restaurant. Staff assisting residents with their meals made conversation that showed interest and familiarity in their residents' family and life history. Residents' independence was also promoted and encouraged.

The Catering Manager supervised a well structured system of service that included meals in the dining area and also tray service to residents in their bedrooms or other preferred locations. A CNM and/or nurse were present throughout the meal ensuring appropriate and safe assistance and monitoring residents intake. It was also noted that the activity team were provided with a list of residents diets and consistency needs when going on outings.

Evidence of referral to relevant allied health professional including dietician or speech and language therapists was found and there was a system in place to monitor the intake of residents identified as at risk of malnutrition although inspectors were told no residents were identified as requiring same at the time of inspection. An in-house nutrition monitoring committee comprised of the ADON, Dietitian and Catering Manager was set up in October 2015 to oversee the management of nutritional care needs of residents. The committee meets monthly and has conducted audits on areas including; policy; training and education; documentation; staff knowledge of residents' dietary needs; menu choice; dining experience; meal choice and provision of healthy snacks. Inspectors found that due to this level of detailed and ongoing review there was a considerable improvement in the management of nutrition in the centre with a notable benefit to the health and well being of the residents.

Judgment:

Compliant

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):

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

Findings:

Overall residents' rights, privacy and dignity was respected with personal care delivered

in their own bedroom or in bathrooms with privacy locks and the right to receive visitor's in private.

Evidence that residents with dementia were consulted with and actively participated in the organisation of the centre was found. . Regular meetings were held where residents were consulted about future activities or outings. Recent events included Spanish Garden and River of life concerts and outing to Glasnevin Cemetery for the 1916 commemoration tour. Feedback on outings held and suggestions for future trips were recorded.

In conversation with several residents all were very complimentary on the level and variety of activities available in Nazareth house. All agreed that there was a very good mix of activities that included physical exercise, quizzes and games and sensory and tactile stimulation using herbs oils bean bags and plastic bowls in games for those with poor hearing and sight. Some said how much they enjoyed the quizzes particularly when residents from other centres came to join them. Others enjoyed the regular outings to local golf clubs, shops and seaside when weather permitted.

Information on the day's events and activities was prominently displayed in the centre. A team of three activities coordinators delivered the programme which included both group and one to one activities. Inspectors were told that one to one time was scheduled for residents with more severe dementia or cognitive impairment who were unable or preferred not to participate in the group activities, and that this time was used for conversation or sensory stimulation using herbs, oils or providing hand massages. Other dementia relevant activities were included in the programme such as reminiscence and sonas.

Good records of the amount of time each resident received on a one to one basis each week were available. The activity staff documented the interaction with the resident, form of activity and materials used and the responsiveness of the resident. For example, where residents smiles following shoulder massage or smelling herbs from the garden. Inspectors noted there was a good emphasis on residents' mental health and well being. This was reflected in the provision of resources such as transport to facilitate individual and group outings, coffee dock and shop and materials and facilities available.

A review of the activity programme to ensure it continues to reflect residents' interests was due to commence. The activity team were reviewing residents' preferences for pastimes with input from relatives.

Records of meetings with relatives were also available. Inspectors noted there was a high level of involvement by relatives in the daily life of the centre. Many residents were taken out on a very regular basis by their relatives and visitors. Others were enjoying the social aspect of the coffee dock, many chatting together, reading newspapers enjoying the adjoining enclosed garden, reading the many notices updating everyone on the progress of the new development or chatting to staff.

Feedback from residents and their relatives on the level of consultation with them and access to meaningful activities was positive. All those spoken too praised the staff for the cheerful and respectful manner in which they delivered care. Residents said staff were quick to respond to their call bells and regularly enquired if they were OK.

Relatives spoken too said they were kept informed of their loved ones condition and could speak to management of they needed too. Many said staff were very attentive and that the standard of care provided and good food was making a positive difference to their loved ones health.

A variety of communication methods were used to keep residents and relatives informed about life in the centre. These included a newsletter that gave feedback on former

outings and events and reminders for those planned. Residents birthdays, staff weddings, engagements or changes were also included.

A notice board was prominently displayed in the reception area that included up to date information on progress of the new service development and building taking place. This was updated on a weekly basis and gave advice on car parking restrictions or other key health and safety information.

Both relatives and staff were also sent text messages to update them on any important or urgent changes concerning the building works and/ or changes in residents' condition. Relatives meetings were also held usually bi annually.

Judgment:

Compliant

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:

There were arrangements in place for regular laundering of linen and clothing and the safe return of clothes to residents.

A policy on residents' personal property was in place and implemented using an inventory on clothes and valuables belonging to residents upon admission. In a sample of those reviewed these were updated.

All clothing was labelled for the laundry and new clothes were added to an initial list by staff.

Adequate space was provided for residents' personal possessions and it was noted that clothing was stored in a neat and appropriate manner.

Judgment:

Compliant

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):

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

Findings:

Suitable and sufficient staffing and skill mix were found to be in place to deliver a good standard of care to the current resident profile.

The staff rota was checked and found to be maintained with all staff that worked in the centre identified.

Systems were in place to provide relief cover for planned and unplanned leave. Actual and planned rosters were in place. Regular staff gave notice to the ADON on their availability to provide cover for unforeseen absences. Then gaps were filled on rota's from this 'bank' of internal relief staff. Although agency staff were still used this had considerably reduced. On this inspection it was noted that most staff were familiar with residents' needs and preferences and replacement staff were appropriate to the role and grade. However it was noted that when CNM's were on leave they were not always fully replaced. Examples of this include where one CNM or more are on AL and there are two to three days where a CNM is not available to cover the units. Although it is acknowledged that the ADON does spend more time on these units where this occurs, it is important that the supervisory presence of the clinical nurse manager is maintained on a daily basis and that non replacement is a rare exception and not a regular occurrence.

A specific staff allocation system was in place that identified the staff for each area on every floor in the centre. All staff were aware of the system which was implemented in full. The system also identified staff supervision of communal areas throughout the day.

It was found that the quality of clinical documentation, together with practices observed, had improved and that a better standard of care was now being provided to resident's. It was also noted that staff were now being provided with better support and supervision by the senior management team specifically the person in charge and the assistant director of nursing who were providing good leadership at operational level on care assessment and planning and the implementation of those plans.

A training plan had not been completed for 2016 but this was forwarded by the person in charge on the day following the inspection.

Most although not all staff were up to date in their mandatory training in protection against elder abuse or fire safety. A considerable number of staff had not received refresher training in either since 2014. This was brought to the attention of the management team and it was noted that a method was not in place to track training expiry dates to ensure a continuum of refresher training is in place. Although refresher training was due for a number of staff in moving & handling, dates were pre-set for this

by the moving & handling training instructor

Training in areas such as food safety; HACCP; dementia awareness and responsive behaviours formed part of the core training for staff on an ongoing basis. Further to the last inspection staff had also received training in clinical areas such as: pressure ulcer prevention; wound care management; medication management and care assessment and planning. The centre's current policy on education and development was reviewed. It included commitments to facilitate nursing staff to achieve post graduate qualifications in relevant expertise associated with older persons care and to provide refresher training in specific clinical areas. However, the policy was not being fully implemented and training had not been provided in some key clinical areas such as; first aid; cardiopulmonary resuscitation; medication management; infection prevention and control or end of life care.

A formal staff appraisal system was not established that discussed the continuous performance and training of staff.

This was discussed with the management team and inspectors noted that a clinical practice competence development programme would benefit staff going forward which should be linked to a formal staff appraisal and development review plan.

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:

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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Nazareth House
Centre ID:	OSV-0000149
Date of inspection:	29/06/2016
Date of response:	02/08/2016

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:

Governance systems in place were not yet fully established or effective. Further development and implementation is required to ensure; effective monitoring processes including a complete audit cycle that contributes to the quality and safety of care in a meaningful way

Governance processes that monitors and develops staff skills and competence to meet the needs of current and future resident profile is required.

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

1. 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 RP & PIC are fully committed to improving & developing effective monitoring processes, developing staff skills & improving the audit cycle for its effectiveness.

1. Governance meetings will continue to take place on a weekly basis. The template used for these meetings has been reviewed to ensure a more thorough analysis of KPI's, audits, actions taken, lessons learned and improvements required. Minutes of these meetings will be fully documented to reflect same.
2. Development of a more robust Quality Assurance programme is currently taking place through the following interventions
 - Key members of the management team are participating in a 5 day Quality Monitoring Systems and Auditing course commencing on August 3rd and to finish on August 11th, leading to a QQI level 6 qualification
3. Audit templates will then be reviewed to ensure action needed is implemented and reviewed for its effectiveness.
4. Performance appraisals have been carried out with all senior clinical staff. Part of this process was to identify their specific individual training needs and organise appropriate training. (Completed July 28th). A plan for performance appraisals for all other staff has been drawn up and will be completed by December 2016.
5. A training plan has been developed for all staff up to December 2016 and adherence to this will ensure all staff has a minimum of mandatory training completed.
6. The Person In Charge is commencing a higher Diploma in Nursing (Advanced Leadership and Management) in September 2016.

Proposed Timescale: 20/12/2016

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 contract of care did not include an option for residents who did not choose to avail of activities and where additional charges applied.

2. Action Required:

Under Regulation 24(2)(d) you are required to: Ensure the agreement referred to in regulation 24 (1) includes details of any other service which the resident may choose to avail of but which is not included in the Nursing Homes Support Scheme or which the resident is not entitled to under any other health entitlement.

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

The contract of care has been amended to show an opt-out clause for residents who do not wish to participate in activities in accordance with Regulation 24(2) (d).

Proposed Timescale: 04/07/2016

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 policies did not give sufficient guidance to staff.

3. 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 RP & PIC are currently reviewing all policies and procedures set out in Schedule 5 to ensure all are detailed enough to guide staff actions to deliver safe and effective care to all residents in particular circumstances.

1.Policies and procedures remain under constant review, in accordance with best practice and at a minimum of three yearly. Reviewed policies are disseminated amongst staff at the time of review.

2.The policy for responding to a missing resident has been amended, made more comprehensive and detailed, with prescribed time frames and geographical parameters, which provide greater guidance for staff. "Walkie Talkies" have been purchased to facilitate staff to communicate with the person leading the search while in the grounds.

3.Personal emergency evacuation plans (PEEP) have been developed and are currently being completed & made known to staff.

Proposed Timescale: 30/08/2016

Theme:

Governance, Leadership and Management

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

Fragmentation of creation, storage and location of records did not enable ease of access or review for staff.

4. Action Required:

Under Regulation 21(6) you are required to: Maintain the records specified in paragraph (1) in such manner as to be safe and accessible.

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

A review of the overall maintenance of records set out in Schedules 3 and 4 under Regulation 21(1) will be undertaken by the RP & PIC to ensure records are safe and accessible.

Schedule 3 – The majority of residents’ records are located in our computer system. Alongside this, each resident has an individual folder with an index and numbering system. This is located in the relevant nurses’ stations and ensures easy access for all members of the care team. The RP & PIC are aware that currently not all resident’s assessments are in the computerised system. This is due to our commitment to develop comprehensive person-centred assessments and care plans. In doing this we have added additional assessments that we are waiting to be uploaded into the care plan system by the computer programmer.

Schedule 4 – These other records listed are all located securely in a filing cabinet in an office, except for Fire Safety which is located in the Fire Box and Directory of Visitors is kept at reception.

Proposed Timescale: 22/08/2016

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:

All risks associated with evacuation procedures were not identified. Personal emergency egress plans did not identify the cognitive understanding, level of mobility or expected level of cooperation of each resident to enable staff respond effectively in an emergency situation.

5. Action Required:

Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

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

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

The RP is committed to ensuring that the health and safety of residents, visitors and staff is promoted and protected at all times.

1.The Risk Management Policy has been reviewed and updated to show changes in personal emergency evacuation plans. This is being disseminated amongst staff to

ensure all are aware of same.

2. Personal emergency evacuation plans have been developed and are currently being completed & made known to staff. They include the level of assistance required, equipment required, special considerations e.g. cognition, unpredictable behaviour.

3. Fire training has been arranged for residents on the 16th of August and will include the evacuation processes. In future all residents will be involved in fire drills where possible.

4. The risk management register has been up-dated to reflect this.

Proposed Timescale: 22/08/2016

Outcome 09: Medication Management

Theme:

Safe care and support

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

Some prescribed medicines were being administered outside the prescribed timeframe due to the length of time taken to complete medication administration rounds.

6. Action Required:

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

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

The PIC is committed to ensuring that safe medication administration practices are adhered to. The prescribed time for administering morning medication is under review by the relevant residents GP's, in conjunction with their pharmacist and will be adjusted accordingly.

1. All registered nurses have been advised of the importance of medication being administered within the correct timeframe.

2. A medication competence assessment has been conducted for all nursing staff.

3. Further training in Medication Management for all nursing staff is due to be completed in August 2016.

Proposed Timescale: 29/08/2016

Outcome 10: Notification of Incidents

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement

in the following respect:

A small number of relevant incidents were not notified to the Chief Inspector as required under Regulation 31.

7. Action Required:

Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

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

The PIC understands that any serious injury to a resident that requires immediate medical and/or hospital treatment, even those where the resident does not require admission must be notified to the Chief Inspector.

The outstanding notifications were forwarded to the inspector on 06/07/16.

Proposed Timescale: 06/07/2016

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:

Assessment and care planning were not specific enough to direct the care to be delivered or guide staff on the appropriate use of interventions to consistently manage the identified need.

Comprehensive nursing assessments were not fully completed for every identified need.

8. Action Required:

Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre.

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

The PIC together with the ADON are fully committed to ensuring that all nursing staff have an excellent understanding in the development, documentation & completion of person centred assessments and care plans to ensure full compliance with Regulation 05(2).

1.All nursing staff received further training on nursing assessments, care planning and accountability on July 20th & 26th.

2.The PIC & ADON will continue to guide and teach nursing staff in development and maintenance of care plans for every identified need.

3.A weekly resident Comprehensive Assessment check list has been developed by the PIC for the CNM's to ensure all sections of identified needs are completed. All of these

are due for completion on August 19th.

4.The ADON is conducting arbitrary spot checks on care plans and her observations will be delivered to the nurse accountable.

5.Auditing of all assessments & care plans will begin on September 5th.

Proposed Timescale: 19/09/2016

Theme:

Effective care and support

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

Reviews of care plans did not include a determination of the effectiveness of the plans to manage the needs identified.

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:

The PIC, ADON, CNM's & nursing staff received further training in documentation of care plan reviews on July 20th & 26th and all now have a better understanding of same.

1.Each CNM is in the process of ensuring all care plans are effective in directing care in an individual, holistic manner.

2.Greater emphasis has been placed on recording the residents' abilities, preferences, wishes and needs. A multidisciplinary approach is being promoted with additional involvement from family members and healthcare assistants.

3.All care plans are reviewed for their effectiveness four monthly or sooner if a residents' condition indicates this. Both the resident and family members are involved in this review.

Completed auditing of reviews will include determining the effectiveness of the care plan to manage the needs identified and goals set for residents

Proposed Timescale: 05/09/2016

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:

Signage and cueing within the centre did not support the freedom of movement for

residents with dementia.

Picture and colour cueing was not found and the function of all rooms within the centre was not identified.

Ramps located on the ground and 1st floors require review to make safe for use by residents with limited mobility using walking aids.

10. Action Required:

Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

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

The RP is fully committed to ensuring that residents with dementia maintain their quality of life and promote their independence.

"Wayfinder" (For dementia friendly environments) signage has been ordered.

This will assist residents identify and move more freely within the different areas of the centre. There will be clear markings to identify the use of a room to support residents with orientation. Colour coding will also be used to help with orientation and alert residents to possible hazards.

The ramps on the ground and first floor will have clear signage to indicate there is an incline and decline.

Proposed Timescale: 22/09/2016

Outcome 18: Suitable Staffing

Theme:

Workforce

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

All staff were not up to date in their mandatory training in protection against elder abuse or fire safety and the staff education policy was not being fully implemented in that training had not been provided in some key clinical areas as identified in the body of the report.

11. 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:

The PIC will ensure all staff completes mandatory training. The PIC will implement the staff education policy by organising relevant training for staff as outlined in the report.

1.A staff training plan for all mandatory training has been put in place for up to December 18th 2016.

2.Some staff whose mandatory training was out of date have been prioritised and

attended mandatory training on July 29th. Further mandatory training for the remainder of these people is planned for August 3rd.

3. Additional dates are arranged for staff that training is due to expire shortly.

4. Further training in Infection Prevention & Control, Falls Prevention, HACCP, Medication Management, Wound care & Responding to Responsive Behaviours is arranged with completion date expected December 19th.

Proposed Timescale: 19/12/2016