Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Nazareth House Nursing Home Sligo
Name of provider:	Nazareth House Management
Address of centre:	Church Hill, Sligo Town, Sligo
Type of inspection:	Unannounced
Date of inspection:	29 February 2024
Centre ID:	OSV-0000369
Fieldwork ID:	MON-0037771

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Nazareth House Nursing Home, Sligo is a modern, purpose built centre that opened in 2007. It replaced an older nursing home building on the site that had been operational since 1910. Residential care is provided for 70 male and female residents who require long-term care or who require care for short periods due to respite, convalescence, dementia or palliative care needs. Care is provided for people with a range of needs: low, medium, high and maximum dependency. The centre is located in Sligo town and is a short walk from bus services and the train station. The building is divided into two residential units- Holy Family and Larmenier. Both units are organised over two floors and accommodate 35 residents. Each unit provides an accessible and suitable environment for residents. Bedroom accommodation consists of 30 single and 20 double rooms all of which have ensuite facilities that include toilets, showers and wash hand-basins. There are additional accessible toilets located at intervals around the units and close to communal rooms. Sitting/dining areas are located on each floor. A range of other communal areas are accessible to the units and include an oratory, a coffee dock, gallery area, library, gardens and a shop that provide additional spaces for residents' use.

In the statement of purpose the provider describes the service as aiming to provide a high standard of compassionate, dignified person centred care in accordance with evidence based best practice. The staff seek to develop, maintain and maximise the full potential of each resident.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	68

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 29 February 2024	18:00hrs to 21:00hrs	Michael Dunne	Lead
Friday 1 March 2024	09:30hrs to 17:30hrs	Michael Dunne	Lead
Thursday 29 February 2024	18:00hrs to 21:00hrs	Nikhil Sureshkumar	Support
Friday 1 March 2024	09:30hrs to 17:30hrs	Nikhil Sureshkumar	Support

What residents told us and what inspectors observed

The registered provider was working towards ensuring that residents' assessed needs were met and that residents were able to enjoy living in the designated centre. Overall residents were content and inspector's observed that residents were supported by a team of staff who were kind and caring. However improvements were required in a number of key areas of the service which are set out in the relevant sections of this report.

The overall feedback from residents was mixed, some residents told the inspectors that they were happy with the care they received and that staff looked after them very well, while other residents said that they felt there was not enough staff available and that they often had to wait for staff assistance to help them prepare for their daily routine. The feedback from residents was validated by the inspectors' findings over the two days of the inspection.

Inspectors carried out the first day of this inspection over an evening and completed the inspection the following day. Upon arrival the inspectors were met by the person in charge and the assistant director of nursing. Following the required infection prevention and control checks the inspectors held an introductory meeting with the management team. The inspectors discussed the purpose of the inspection which included a review of the provider's compliance plan arising from the last inspection held in March 2023.

After the introductory meeting one inspector attended Larmenier unit while the other inspector attended Holy Family Unit. On the evening of the first day, inspectors observed that staff were busy providing care and support to residents who wished to retire to their rooms or to bed. Staff interactions with residents were respectful and empathetic.

A significant number of residents were assessed as maximum dependency and required the support of two members of staff to access their bedrooms and prepare for bed. The inspectors observed that there were not enough staff available on either of the units which meant that whilst staff were busy helping residents going to bed those residents who walked with purpose were left largely unsupervised and did not receive timely support from staff. In addition those residents who remained in the sittings rooms before retiring to bed were left without support and supervision during this period.

The centre comprises of two self contained units, Holy Family and Larmenier. Each unit provides accommodation for 35 residents. Accommodation is provided in a mixture of 30 en-suite single bedrooms and 20 twin bed en-suite bedrooms with each unit identical to each other in terms of layout. Communal day spaces consisted of a home style layout with a living area complemented by an adjoining dining space. All of the home style living areas were found to be well laid out with sufficient seating and tables available for the residents to use. These areas were

well used by residents throughout the day and evening.

Resident rooms were tastefully decorated with personal items, pictures of family members and individual memento's. Rooms were spacious and comfortable with sufficient storage space available for residents to store their personal belongings. Rooms were also observed to contain televisions, suitable seating for residents to use, and there was lockable storage available for residents to store their treasured items securely. There were however a number of areas which required repair. The provider had updated information technology systems in the centre, and these works had caused some damage to the fabric of the building. This damage also impacted on the effectiveness of fire safety and infection control measures in the designated centre.

The majority of communal areas were tastefully decorated, with corridors adorned with paintings created by residents. However,Inspectors observed wear and tear on furniture and damage to some doors in the centre. There were stains and mal odours eminating from carpets on both of the units inspected. Inspectors noted that the provider had changed the flooring on the ground floor in Lamenier unit and the person in charge confirmed that there were plans to replace carpets in other area's of the centre however the time line for this to be completed was not known at the time of the inspection.

There is a hairdressing facility which is available for residents three days a week. A cafe style coffee dock and was observed to be well attended by residents and their relatives. This facility was open to residents and their relatives and friends as an alternative meeting place outside of the residents individual rooms on their residential unit. There was also a dedicated visitors room available on the ground floor should residents wish to meet their relatives in a quiet space.

A shop was located on the ground floor which was operated by volunteers and contained various items of confectionery and stationary, this facility was now open from 11.30am until 2.30pm one day a week, although residents could place orders for items they wanted outside of this time. An activity room was located on the ground floor and was furnished with items from times past, such as transistor radios, a range for cooking, a spinning wheel, and an old fire place.

There were a number of storage facilities located on each floor however inspectors found the provider had failed to improve storage facilities in the centre since the last inspection. For example items of resident mobility equipment was still being stored in communal areas of the centre. This impacted on infection prevention and control measures and also on resident safety. In addition, the inspectors found that a resident's bed was being stored in a corridor area on Larmenier unit.

Following the previous inspection the provider had introduced additional activities in order to provide meaningful occupation for residents, however the inspectors found that most residents residents were still spending a lot of time with nothing to do but watch television. A review of planned activities confirmed that one music activity was available on the first day of the inspection. Observations on the second day confirmed that while staff were available in the communal areas their role was

largely to supervise residents and only minimal effort was put into organising and providing meaningful activities for the residents. Furthermore a review of the roster confirmed that dedicated activity staff were available in the centre four days out of seven each week, however it was not clear on the rosters what staff were allocated responsibility for organising and providing activities for residents outside of these times.

A meal service was observed on the evening of the first day. Inspectors saw that residents were provided with a selection of sandwiches, cakes, teas, coffees and drinks. Residents who spoke to the inspectors said that they were happy with the quality and quantity of the food provided.

Residents who spoke with the inspector said that they felt safe in the centre and that if they had a concern that they could talk to any member of the staff team. The inspector found that staff were compliant with their safeguarding training and those spoken with were clear about their role and responsibility in maintaining residents safety and in identifying any concerns that needed further investigation.

Residents were observed to move about freely within their own unit, while residents who were safe to access other areas of the centre were provided with the relevant key pad codes. The provider had identified a dementia friendly area within one of it's units which supported residents who walked with purpose and facilitated their unrestricted access to a safe and secure garden area.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

The inspectors found that a number of improvements were required in relation to the oversight and management processes to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

This was an unannounced inspection carried out by inspectors of social services to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) 2013 (as amended). Inspectors also followed up on the compliance plan received from the provider following the previous inspection held in March 2023.

The inspectors found that the compliance plan submitted by the provider had not been fully implemented and identified a number of repeated non-compliance's regarding Regulation 15 Staffing and Regulation 23 Governance and Management. Additional non-compliance's were found on this inspection and these are discussed under the relevant regulations.

Three pieces of unsolicited information had been received by the Chief Inspector since the last inspection and these were followed up on this inspection. The issues reported to the Chief inspector related to the staffing levels in the centre and the lack of the provision of meaningful activities for residents. This inspection found these concerns to be validated and the inspector's findings are discussed under Regulations 15 Staffing and Regulation 9 Resident's Rights.

Although, the provider had comprehensive risk management policies and procedures in place the inspectors found that these policies were not being implemented consistently and that the oversight of risk management in the centre did not promote a safe environment for residents. This was of particular concern in relation to the management of fire safety risks in the centre. As a result, inspectors issued an urgent compliance plan to the provider to address poor compliance in relation to Regulation 28 Fire Safety . Following the inspection the provider submitted an acceptable compliance plan to address the risks identified in the urgent compliance plan.

Nazareth House Management is the registered provider for Nazareth House Nursing Home which was developed by the Sisters of Nazareth, in 2007. The registered provider was in regular contact with the management team working in the designated centre. The registered provider also maintains centralised departments such as human resources, information technology, staff training and finance all of which the centre's management team have access to.

There was a well-established nursing team in the centre, with the person in charge supported in their role by an assistant director of nursing, two clinical nurse managers and a team of nurses. The team also included health care assistants, activity staff, maintenance and a part-time physiotherapist. A number of ancillary services provided by the designated centre had been outsourced including house keeping, catering and laundry support. The registered provider has service levels agreements in place for these services however this inspection found that the oversight of cleaning services was not robust and did not ensure that the service met the required standards.

Inspectors found that there was insufficient numbers of staff available during the evening to provide timely support to residents. As a result on the evening of the inspection residents were waiting for staff to become available to attend to them. In addition residents who were still up and about including those residents living with dementia and who walked with purpose did not have sufficient levels of supervision to maintain their safety in line with their care plans.

The inspectors reviewed a sample of governance and management documentation including audit records, meeting minutes and complaints. Incident records, the risk register and associated risk management contingency plans. The inspectors found that although there were systems in place to monitor the quality of care and services provided, they were not effective in identifying and addressing where non compliance occurred. For example a number of infection control audits consistently recorded poor compliance with the national standards however the associated improvement action plans had not been implemented effectively which resulted in

standards not improving.

The provider made available their annual review of quality for 2023 dated January 2024. The review included information gathered from a resident's satisfaction survey carried out in February 2023. While residents responses were in the main positive and identified that they were happy with the care provided, other responses identified that staff are always busy and always in a hurry to complete tasks. There was no clear action plan in the annual review to address this feedback. This document also identified a number of service improvements to be completed in 2024 including a review of fire prevention measures, and a refurbishment plan for the centre to include storage facilities.

The provider had revised their statement of purpose in November 2023 with updated information in line with the requirements of Schedule 1 of the regulations. However, the document did not include details of all of the additional charges that resident may be liable for.

Regulation 14: Persons in charge

There was a person in charge who was solely employed in the designated centre and met the requirements as set out under regulation 14. The person in charge was appointed to their current role in 2023.

Judgment: Compliant

Regulation 15: Staffing

The inspectors were not assured that the provider had the required numbers of staff available with the required skill mix having regard of the size and layout of the centre and the assessed needs of the resident's. For example,

- The staffing resources available to provide and co-ordinate meaningful activities and social engagement for all residents were not sufficient to ensure all residents were afforded the opportunity to engage in meaningful activities in line with their interests and capacities. As a result residents were disproportionately dependent on watching television to occupy themselves.

There were insufficient numbers of staff available in the evening to ensure that residents were provided with the required levels of supervision and support to meet their assessed needs. For example,

- Residents who walked with purpose were not provided with support to ensure that their care and welfare needs were met in a timely manner.
- There were insufficient numbers of staff available during the evening time to

provide supervision to residents who remained in the communal sitting room.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider did not ensure that the designated centre had sufficient resources available to provide care in accordance with residents assessed needs. For example,

- Staffing resources were not being managed effectively to ensure that residents assessed needs were met in a timely manner, this is discussed in more detail under Regulation 15: Staffing.
- The provider failed to ensure that resources were made available to provide suitable storage facilities in the designated centre.

There was a management structure in place, which identified roles and responsibilities and reporting structures. However this was less well established for those areas of the service that were outsourced. For example,

- The delivery and management of housekeeping tasks was outsourced to a private company. The inspectors found that there were inconsistencies among some of the staff employed by the provider and staff employed by the cleaning company regarding the overall responsibility for cleaning standards in the centre.

The management systems reviewed on the day of the inspection did not provide assurances that the service provided was safe, appropriate and consistent. For example,

- The oversight of cleaning practices was not effective and did not ensure that the standard of cleaning was adequate in a number of areas in the designated centre.
- Information collected through the centre's auditing processes was not effectively used to bring about the required improvements. A number of audits made available for the inspectors to review had identified a number of areas that required improvement however the associated action plans were not followed through to bring about the required change.
- There was a poor appreciation of risk in relation to fire safety,infection control and storage of equipment. As a result a number of risks had not been identified and addressed.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Inspectors reviewed records in relation to contracts for the provision of services and found that a number of alterations were required to ensure that these records were clear and met the requirements of the regulations, for example:

- Contracts prior to 2022 did not identify the room number on the contract for the provision of services, however the provider ensured these omissions had been addressed and that all contracts now identified the relevant room number.
- Eight resident contracts were found not to be have the appropriate signatures in place, although the provider had engaged advocacy services to support a number of residents with their contracts.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had a statement of purpose in place which included the information set out in Schedule 1 of the regulations. However this document required amendment to accurately reflect the current service, this is also discussed in more detail under Regulation 20 information for residents.

Judgment: Compliant

Regulation 34: Complaints procedure

There was an accessible policy and procedure in place for dealing with complaints received by the provider.

The inspector reviewed the complaints log and confirmed that the provider had received three complaints since the last inspection, two of which had been closed off in line with their policy and there was one complaint which was being managed in line with the centres complaints procedures but had not been resolved at the time of this inspection.

Judgment: Compliant

Quality and safety

The quality of care delivered to residents was generally of a good standard and was person centred. However, the lack of access to meaningful activities and to the local community meant that a number of residents spent a lot of time with little of interest to stimulate and engage them during the day. In addition, significant improvement actions were required to bring the centre into compliance with fire safety precautions and infection prevention and control processes so that residents were adequately protected and to ensure that the resident's lived environment was well maintained. Furthermore, the inspectors were not assured that the centre's infection prevention and control practices were maintained to a high standard and several areas of the centre were visibly unclean on the first day of the inspection. This was brought to the attention of the person in charge.

Residents had timely access to medical assessments and treatment by their general practitioners and access to a range of allied healthcare professionals, such as dietitians and speech and language therapists was organised when needed. However, the inspectors found that appropriate re-referrals had not been made to a wound care specialist when one resident's wound had deteriorated.

The inspectors reviewed a sample of care files and found that overall the residents' admission assessments and care plans were detailed, and care plan reviews and updates were carried out for residents at regular intervals or if the residents needs changed. However, the inspectors found that some residents with responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) did not have a care plan in place to guide staff in managing the resident's responsive behaviours. Additionally, some other residents who did have a care plan in place for managing their responsive behaviours did not have their care plans implemented by staff to ensure that the resident was supported in line with their assessed needs.

The centre's premises were generally well laid out. However, the inspectors observed that the centre's internal premises were in a poor state of repair and required improvement actions. Additionally, the storage of equipment in some communal areas did not allow residents to move around the centre safely. This is a repeat finding from previous inspections that had not been addressed in line with the compliance plan submitted by the provider following the previous inspection.

The inspectors found that the centre's fire precautions required significant improvement, and an urgent compliance plan was issued requiring the provider to bring the centre into compliance with Regulation 28 within a time frame set by the Chief Inspector. The provider submitted a satisfactory response to the urgent action plan following the inspection. In addition following the inspection, the provider committed to carrying out a full fire safety risk assessment of the centre by a competent person.

There was a resident guide dated 7th of February 2024. The guide referenced a separate document where the terms and conditions of residence were identified

however the specific details were not included in the resident's guide in line with the requirements of the regulations.

Food appeared to be well prepared and nicely presented. Residents who required support with their eating and drinking were provided with timely support, and meal times were social occasions for the residents.

There were no restrictions on visiting, and the inspectors observed visitors coming and going on the two days of inspection. The visitors who spoke with the inspectors were happy about the current visiting arrangements.

Residents had easy access to televisions, newspapers, and radios to stay informed in the centre.

The centre had notice boards in both units containing information on upcoming events and activities, such as tattooing programmes, which helped to promote a sense of community and engagement among the residents.

The inspectors also observed that the residents were supported in participating in the national referendums to exercise their civil rights and were given the necessary resources and assistance to help them participate in these referendums.

Residents' meetings were held regularly in the centre, and the residents were consulted to participate in the organisation of the centre.

The inspectors observed that although an activity program was available for residents, the current schedule of programs was insufficient to meet the needs of the residents. The inspectors observed that several residents were not sufficiently supported to engage in meaningful activities throughout the day that were in line with their care plans, and this was a repeated finding from the previous inspection.

Regulation 10: Communication difficulties

Residents who were assessed having difficulty in communication had an appropriate care plan developed to guide staff to support their communication needs.

Judgment: Compliant

Regulation 12: Personal possessions

Residents were supported to maintain control of their clothing and personal belongings. Residents' clothing was laundered on-site and returned to them. Residents had adequate storage space in their bedrooms including a lockable space

for their valuables if they wished.

Judgment: Compliant

Regulation 17: Premises

There were a number of recurring non compliant findings relating to the premises where the designated centre did not meet the requirements of Schedule 6. There was insufficient storage available to store clinical equipment in the centre. For example:

- The inspector noted that equipment such as hoists was stored in the corridor. This equipment restricted residents' access to handrails in the ground floor corridors of both Larmenier and Holy Family units and did not allow them to safely and independently move around the centre.
- The personal care products and linen were in a storage cabinet placed along a corridor wall. The cabinet did not close securely, which posed a risk of contamination of these products.
- Disposable gloves were stored on a table in the dining room of the Larmenier unit. The gloves were not contained in a secure container, which posed a risk that residents with cognitive impairment may accidentally ingest the gloves and create a choking risk.

The provider had not kept all areas of the centre in a good state of repair. For example:

- The corridors near the communal toilets on the ground floor of the Larmenier and Holy Family units had a malodour, which had not been identified and addressed by staff.
- Worn and damaged carpets restricted effective cleaning, and the damaged areas had not been repaired in a timely manner.
- Some wall and ceiling surfaces of corridors and storage rooms of both Larmenier and Holy Family unit needed painting and repair.
- Several door frames and were visibly damaged and required repair.

Judgment: Not compliant

Regulation 20: Information for residents

The provider prepared a residents guide dated February 2024. However, although there is reference made to contracts for the provision of services there was insufficient detail provided, regarding:

- The terms and conditions relating to residence in the designated centre.

Judgment: Substantially compliant

Regulation 26: Risk management

The centre had an up-to-date risk management policy in place which included all of the required information as set out under Regulation 26. The failure of the provider to identify and manage risk appropriately is discussed under Regulation 23: Governance and Management.

Judgment: Compliant

Regulation 27: Infection control

The provider did not ensure that infection prevention and control procedures were consistent with the national standards for infection prevention and control in community services published by the Authority.

The environment was not managed in a way that minimised the risk of transmitting a health care-associated infection. This was evidenced by:

- An armchair located in a communal area could not be cleaned effectively due to foam filling protruding through the leather cover.
- Residents' incontinence wear was stored loosely in a number of unsecured cupboards and this did not ensure that these products were kept clean.
- There was no hand washing sink available in the cleaner's room.
- There were holes in the walls of a sluice facility which meant that this area could not be effectively cleaned.
- The carpets were visibly dirty and stained in several areas.
- Used disposable gloves were discarded onto a dining room table in Larmenier units.

Equipment was not consistently decontaminated and maintained to minimise the risk of transmitting a health care-associated infection, For example:

- The system in place to ensure that resident mobility equipment was cleaned in between resident use, was based on a verbal guarantee that equipment was cleaned by staff after each use, however this system was not robust as a number of hoists were observed to be visibly dusty.
- Inspectors found wheelchair equipment used to assist residents with their mobility stored in a dirty utility room.

Judgment: Not compliant

Regulation 28: Fire precautions

The Inspectors were not assured that the provider's day-to-day arrangements in place to review the fire safety risks and fire precautions against the risk of fire were not effective. For example:

· Combustible and flammable materials were inappropriately stored in a plant room located in the basement of the centre. For example, this room had inappropriate storage of flammable items such as books, several cardboard boxes, plastic containers, and chemical bottles containing solvents and white spirits. In addition, an unexplained burn mark was visible on the ceiling of this plant room.

· A medical oxygen treatment plant room had a room with in this room that was used as an electrical panel room. The inspectors observed combustible and flammable materials being stored in this electrical distribution rooms, which posed a risk of fire in this area.

· There were two main fire panels located on the ground floor of the laminar unit and holy family unit; however, there were no repeater panels on the first floor of these two units. As a result, staff had to leave the unit and travel to the main panels to identify the location of the fire. Several staff who spoke with the inspectors did not demonstrate sufficient knowledge and awareness regarding the procedures to be followed in the event of a fire, such as horizontal evacuation procedures, access and location of fire alarm control panels and personal emergency evacuation procedures.

· There were insufficient emergency lighting in some areas of the centre.

· The provider had not maintained the means of escape for residents in the ground floor of laminar unit and holy family unit. For example, wardrobes and PPE storage units , linen trolleys were stored in protected corridors.

· The inspector observed that the emergency lighting in five locations required replacement bulbs which had not been replaced in a timely manner. In addition, several running man signage located across laminar and holy family unit had not been illuminated due to damaged bulbs and the bulbs had not been replaced in a timely manner.

· The directional signage in the ground floor of holy family unit was confusing, which could potentially the delay fire evacuation procedures in the event of a fire emergency.

· Arrangements for containment of fire in the event of a fire emergency in the centre were insufficient. For example:

. There was an open-plan kitchenette and dining room on both floors that contained electrical equipment such as a dishwasher and a fridge. This room was located between two compartments. From a review of the fire evacuation plans, this room was indicated as a primary escape route to be used in the event of a fire emergency from the adjoining bedroom compartments. The inspectors were not assured this escape route was suitable as a primary means of escape as there was a lack of a protected corridor. In addition to this, the escape route could potentially be compromised due to the presence of kitchen equipment . Furthermore, the inspectors were not assured this room formed part of the daily checks to ensure the escape route was free from obstruction. As such this required a review from the providers competent fire person.

· There was insufficient fire stopping around electrical cabling that penetrated through the walls and ceilings in several areas. Furthermore, there were holes in fire rated walls and ceilings of high risk areas such as kitchenettes, electrical distribution rooms, medical gas treatment room, and plant rooms and sluice room As a result, the inspectors were not assured that the centres fire compartments were intact to contain spread of smoke and toxic fumes in the event of a fire emergency.

· The inspectors were not assured of the ability of some of the fire doors in the centre to prevent the spread of smoke and fire. For example, the inspectors observed one fire door in laminar unit and two fire doors in holy family unit that were visibly damaged. In addition, the inspectors were not assured that those fire doors that had been replaced were fitted to the required standards by a competent person.

· The centre has two units laid out on two floors with a lift and stairways connecting the two floors. The lift well appeared to be enclosed by walls with 60 minutes of fire resistance. However, the lift door opened directly into a corridor leading to residents' bedrooms. Inspectors were not assured that the fire compartmentation in the lift lobbies on each floor was adequate to prevent the vertical spread of smoke and fire into the resident bedroom corridors.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

The provider had not ensured that appropriate care plans were developed for residents following their admission to the designated centre. For example:

- Three residents who were assessed as at risk of absconding from this centre did not have an appropriate care plan to inform staff about the actions they needed to take to meet the residents' needs and promote their safety if the resident displayed exit seeking behaviours.
- Two residents did not have an appropriate up-to-date social care plan in

place that included their preferences and needs in relation to meaningful activities and social engagement.

Judgment: Substantially compliant

Regulation 6: Health care

The inspector reviewed a sample of nursing records of some residents, and the records indicated that one resident had not been provided with wound care at appropriate frequencies in line with the wound care specialist's recommendation. Moreover, appropriate re-referral had not been made to the wound care specialist when the resident's wound failed to heal for five months.

The inspectors observed that where two residents had a behavioural support care plan to manage the risks arising from their wandering behaviours, this had not been fully implemented. For example, the non-pharmacological measures mentioned in their care plans, such as meaningful activities and one-to-one support to de-escalate their responsive behaviours, were not been provided during the first evening of the inspection. As a result, the inspectors found that the residents were unsupervised and were observed going into high-risk areas, such as kitchenettes and sluice rooms, which posed an injury risk.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had not taken all reasonable precautions to protect the residents from abuse. For example, two residents who were involved in a recent safeguarding incident did not have an appropriate safeguarding care plan in line with the National Policy and Procedures for Safeguarding Vulnerable Persons at Risk of Abuse 2014. Furthermore, these residents did not have an appropriate responsive behaviour care plan in place to prevent the occurrence of similar safeguarding incidents.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents were not provided with opportunities to participate in activities in accordance with their capacities and capabilities. For example:

- There was a lack of staff available on the evening of the inspection which left

residents without any meaningful interactions or support to meet their needs.

- Furthermore, on the second day of the inspection, the activity staff were unavailable to provide any engaging activities for the residents in both units. The inspectors also did not observe any planned social care programmes being offered to residents on the second day of the inspection. This lack of social care programmes and activities was negatively impacting the residents' quality of life and well-being. In addition, one of the residents informed the inspectors that they weren't receiving enough support to go out for their social care needs, which made them feel isolated and disconnected from their community.

The provider failed to ensure that residents were able to exercise their civil liberties in regard to changes made by the provider in the contract for the provision of services. For example,

- The provider was found to have charged a number of residents for additional charges without having obtained their written consent beforehand. This was addressed by the provider following the inspection and inspectors received assurance that the residents had been re-imbursed.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Not compliant
Regulation 20: Information for residents	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Nazareth House Nursing Home Sligo OSV-0000369

Inspection ID: MON-0037771

Date of inspection: 01/03/2024

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 1. Activities have increased by 20 hours per week to a total of 52 hours activity per week. Activity co-ordinations are rostered for 7.5 hours per day from Monday to Saturday and 5 hours per day on Sunday. 2. An activity calendar has been developed for extra independent activities such as Music, Reiki, Keep Fit, Bowling etc. 3. Management will ensure that there is always a HCA on both units until 10pm to assist residents late into the evening. All above points above will be completed by the 30th May 2024.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. As per response in Regulation 15: The Activity scheduling will be increased, and HCA's will be rostered on both units so as to ensure adequate resident assistance and additional opportunity for meaningful activities – See Reg 15 Staffing. This will be complete by 30th May 2024. 2. Storage arrangements have been reviewed and re-allocated to alternative areas. This has been completed. For list of actions taken in relation to storage please see our	

comments in Regulation 17: Premises.

3. It has been clarified to all staff where the responsibility lies for the cleaning of clinical equipment. Our HCA's clean all of the clinical equipment such as Wheelchairs, hoists etc. Aramark staff perform all other cleaning duties. All cleaning schedules are recorded for transparency and IPC governance. A new cleaning policy has been developed and implemented in partnership with Aramark. Our PIC meets every Monday with Aramark to review cleaning schedules and discuss any IPC matters.

4. Two IPC nurses rostered each week, they will assist us to come into compliance by:
a. Organizing intensive IPC training for staff each week, in accordance with best practice IPC guidelines.
b. Review of cleaning activities and operations to ensure compliance with IPC guidelines.
c. Review Aramark cleaning audits to ensure accuracy and IPC compliance.

5. In relation to Fire Safety & IPC A number of action plans are in place such as:
a. Environmental Fire Safety Risk assessment check list is completed weekly. I attach a copy of the most recently completed risk assessment as proof.
b. Weekly fire drills rotate on each of the two units.
c. Weekly documented equipment cleaning checklist is now in place.
d. Aramark complete a monthly cleaning audit, with corrective actions where necessary.
e. Aramark management provide unannounced external audits monthly.
f. PIC hosts fortnightly dedicated meetings with Aramark to address any cleaning concerns.
g. IPC /Fire Safety/ Facility Management matters are addressed at our HOD meeting every Monday morning.
h. PIC ensures that every month an environmental infection control checklist (bedroom audit) is completed.
i. We are due to receive Independent Fire Risk Assessment report on Friday the 17th May. All issues in this report will be actioned without delay.

Regulation 24: Contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
1. An amended contract of care is being issued to all new residents and will be in place by the end of June 2024. This will clarify the issue of signing the contract and the time frames before it becomes a contractual agreement. The contract being used by NH Sligo is the NHI agreed contract of care and is CCPC compliant. We have customised it in only a few very minor areas, e.g. such as ASC charge rates, fees chiropody, hairdressing etc.
2. Additional records will be maintained of communication, whether written or verbal, relating to the signing of the contract of care. This has already been enacted.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
1. Additional storage has been made available for the storage of hoists. For example
a. Staff changing room has moved to the basement, this added 4 additional storage rooms. Two in Holy family and two in Larmenier.
b. We have removed all equipment, hoists, cupboards from the hallways.
c. Housekeeping equipment rooms have been relocated upstairs on each floor.
2. Corridor cupboards have been removed – Completed.
3. PPE – storage and education of staff has been addressed, including disguising the PPE dispensers to avoid removal of items by residents.
4. Carpeting – Larmenier ground floor carpets have already been removed and replaced with hard flooring. Holy Family carpets have now also been replaced.
5. Identified areas of walls and ceilings have been re-decorated – Complete, but this is an on-going programme of re-decoration.
6. Door frames – All doors have been independently inspected by an approved Fire Safety Specialist, report is due on Friday the 17th May. This report will be shared with HIQA as soon as we receive it. Any items requiring action will be addressed immediately. Our maintenance manager completes weekly check of fire doors following his weekly environmental audit, this is discussed with the PIC every Monday at our HOD meeting

Regulation 20: Information for residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 20: Information for residents:
1. The residents guide will be reviewed to include full documentation of everything required by our residents and their families – to be completed by 30th May 2024.

2. Contracts of care in Nazareth House Sligo are based on the NHI templates and in accordance with CCPC guidelines.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
1. New furniture was ordered on the 26th February 2024 (prior to inspection) to replace all damaged items. There is a lead time as furniture is made to order – 6- 8 weeks.
2. Remove all damaged items when new furniture arrives, in the meantime any exposed material has been covered with washable tape.
3. All cupboards in corridor removed – completed.
4. Holes in walls are now backfilled with fire stopping material – completed.
5. Carpet removal and new flooring installation is being done in stages and is in progress. This is to ensure minimal disruption to residents. We aim to have this fully completed by the 30th July.
6. Staff have been reminded not to discard gloves or any item of PPE in inappropriate places, this is raised at the safety pause, which are now being documented. Additional training dates are being arranged for May and June 2024. The PIC audit compliance with this during her daily walk of the building.
7. It has been clarified that the cleaning of wheelchairs and other clinical equipment is the role of the Care staff, re-introduced a set schedule for this purpose and it is a requirement to document the completion of these tasks. Continued focus on this comes from staff meetings, bulletins and safety pause.
8. In relation to the provision of sinks in cleaning rooms we have taken the following actions:
a. We have moved the housekeeping room to two different locations (upstairs in Holy Family and upstairs in Larmenier) where we can access services to water to allow us to install sinks.
Our maintenance manager has contacted a plumber and is awaiting a quotation before installing same. This will be completed by the end of July 2024.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. Basement areas has been cleared; any flammables have been stored correctly - Completed
2. Identified areas in basement have been painted. Completed
3. All combustibles have been removed from medical oxygen room – adjoining door repaired. Completed
4. The fire panels have been inspected and reviewed by the independent fire safety specialist. The report is awaited and will be shared with the HIQA inspectors on receipt. In the interim the use of walkie talkie are in situ to allow staff to communicate with each other.
5. The insufficient emergency lighting – replacement elements were on order and have since been received and fitted. Complete
6. Directional signage and emergency lighting queried by HIQA – All lighting bulbs have been replaced and are in working order. Fire Safety specialist is advising on directional signage – we await the report.

7. Kitchenettes – Assessed by independent fire safety specialist – awaiting report.
8) All staff had attended mandatory fire training which includes theory and site-specific details, practical fire evacuation and use of fire extinguishers. We have completed a staff fire handbook that is site specific to NH Sligo. This has been given to every staff member and senior management will do spot checks of staff knowledge. We have attached this booklet with the compliance plan.
8)The issue of the lifts has been assessed by the Independent Fire safety specialist and the report is awaited.
9)All gaps recently made by the recent installation of the upgrade of IT system and new call bell systems has been filled in with fire stopping material. Completed.
10) Additional training has been implemented and remains continuous.
• Safety Pauses
• Weekly fire Drills
• Booklet given to all staff
• Pocket card with instructions created.
11) A weekly environmental fire risk assessment has been introduced for March and April with Action plan, thereafter this will become monthly. The action plan will be reviewed at the next assessment date by DON/ADON/CNM. Our Fire Safety register booklet includes a weekly check on all fire doors.
12) Our Independent Fire Risk Professional has completed a check of all fire doors and we will receive his report on the 17th May, any actions recommended will be implemented immediately.
13) Night nurses on duty walk the building each evening to perform checks on all fire doors for inappropriate propping open of doors.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
All residents have now been reassessed and we have completed updated documentation for safety/risk of elopement. Social care plans are now in place in relation to meaningful activities and social engagement for each resident.

Workshops have been planned to commence on the 25th April 2024 and will cover the following areas:
• The correlation between identifying clinical risks and care planning
• Care plan writing
• Understanding the non-cognitive symptoms of dementia
• Understanding that behaviour is a means of communication

Our aim is to complete the workshops by the end of May.
This will be followed up with bi-monthly audits, this will enable the workshops to be evaluated as to their effectiveness and to identify any further short-comings.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
1. Residents are checked daily for any wounds, any skin changes are identified and documented by the nurse or the HCA. The wound will be checked twice daily and any further care required will be actioned.

2.PIC has introduced a new board for wound management at each nurse's station. This forms part of the handover also.

Identified shortcomings in documentation – this has been addressed with the Nurses involved, however, training will be repeated in the workshops as stated in Regulation 5.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
1. All residents have now been reassessed and all documentation has been updated for safeguarding.

2. PIC has implemented new care plans that include options to update data relating to Elopement, Meaningful activities & Social Engagement.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
1. Action plan as per Reg 15 Staffing – 9pm evening shift on both units will assist us in observing the day room and provide assistance to any residents wandering with purpose.

2. Activities take place 7 days a week and an activity calendar is in place to advise residents of what activities are on each day.

3. On the day of inspection HIQA discovered eight contracts with no signature. All of

these contracts are now signed. Four of these contracts had Sage involvement.

4. New contracts of care have been developed (as per NHI template) to ensure full compliance with resident's rights – these contracts are also CCPC compliant. We will ensure all contracts are signed in advance before admitting any long-term beds.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	30/05/2024
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	30/06/2024
Regulation 20(2)(b)	A guide prepared under paragraph (a) shall include the terms and conditions relating to residence in the designated centre	Substantially Compliant	Yellow	30/05/2024

	concerned.			
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	30/05/2024
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Substantially Compliant	Yellow	30/05/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/05/2024
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms	Not Compliant	Orange	30/06/2024

	relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	31/07/2024
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Red	08/03/2024
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Red	08/03/2024
Regulation 28(1)(c)(i)	The registered provider shall make adequate	Not Compliant	Red	08/03/2024

	arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.			
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Red	08/03/2024
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Red	08/03/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	08/03/2024
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	31/05/2024
Regulation 5(3)	The person in	Substantially	Yellow	31/05/2024

	charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Compliant		
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Substantially Compliant	Yellow	15/06/2024
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	30/05/2024
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	30/06/2024

Regulation 9(3)(e)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise their civil, political and religious rights.	Not Compliant	Orange	30/06/2024