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 Care Ireland
Address of centre:	Church Hill, Sligo Town, Sligo
Type of inspection:	Unannounced
Date of inspection:	25 October 2024
Centre ID:	OSV-0000369
Fieldwork ID:	MON-0045093

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:	66

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
Friday 25 October 2024	09:15hrs to 17:30hrs	Michael Dunne	Lead
Friday 25 October 2024	09:15hrs to 17:30hrs	Gordon Ellis	Support

What residents told us and what inspectors observed

On the day of inspection, the inspectors observed that residents were supported to enjoy a satisfactory quality of life supported by a team of staff who were kind, caring and responsive to their needs. The overall feedback from residents and visitors was that they were happy with the level of care that is provided and that staff looked after them very well. Some residents told the Inspectors that " they love it here" and that "staff look after them very well". While, visitors to the centre said that "staff do a good job, but sometimes they are very busy".

Inspectors were met by staff who guided them through the infection prevention and control measures that were in place prior to accessing the designated centre. During an introductory meeting, with the person in charge and with the provider's chief nursing officer, the inspectors outlined the purpose of the inspection, which included a review of the provider's compliance plan arising from the last inspection held in February 2024. Following this meeting, the inspectors commenced a walk around the designated centre where they had the opportunity to meet with residents, staff and visitors who were in attendance.

The centre comprises of two self contained units called Holy Family and Larmenier. Each unit provides accommodation for 35 residents over two floors; the ground and first floor. Accommodation is provided in a mixture of 30 en-suite single bedrooms and 20 twin bed en-suite bedrooms with each of the units identical to each other in terms of layout. Communal day spaces consist 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 dining tables for residents use. Inspectors observed that these areas were well used by residents on both units.

Resident rooms were decorated with personal items such pictures of relatives and individual items and memento's. There was sufficient storage space available in these rooms for residents to be able to store and access their personal belongings. There was a range of suitable seating in place and all resident rooms were observed to contain a television, a lockable storage unit available for residents to store their treasured items securely. The provider had addressed areas of the premises that required repair. Inspectors observed that flooring had been replaced both in communal and resident bedrooms. Damage to walls had been repaired and repainted.

A range of other facilities were available for residents to use and included a hairdressing facility, and a shop that stocked confectionery, stationary and toiletries. As this facility was no longer open during the day, staff took residents orders for goods and delivered them to residents on their units. The coffee dock and was observed to be well used 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' bedrooms.

The centre was clean and inspectors observed good infection prevention practices performed by staff. Staff were knowledgeable about cleaning procedures and on how effective cleaning routines maintained an infection free environment. There were ample supplies of wall mounted hand sanitizers and clinical hand wash basins throughout the centre. The inspectors visited the laundry and sluicing facilities in the centre and found them to be suitable for their intended purpose. The provider had made a number of changes to their storage facilities which ensured that there was appropriate segregation of clinical and non clinical items. All equipment used to support residents with their care needs was observed to be clean and well-maintained.

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 was also a dedicated visitors room available on the ground floor should residents wish to meet their relatives in a quiet space.

Staff demonstrated good skills and knowledge using appropriate techniques to encourage residents to participate in activities in line with their capacity to engage. At the time of this inspection the centre was decorated with a range of items celebrating the festival of Halloween, and resident's were looking forward to an arranged music session later that afternoon. A Halloween party was also planned to take place in the coffee dock. Inspectors observed residents being supported by staff to engage in individual and group activities. Some residents were observed reading their local newspapers and discussing items of interest with the staff while others were engaged in a question and answer session. The variety of activities available for residents to engage in had greatly improved since the last inspection and is discussed in more detail under Regulation 9: Residents Rights. An activity schedule was advertised in the centre which gave residents information on the activities available on a day to day basis.

Inspectors observed that some residents attended the dining room for mealtimes and appeared to enjoy the social interaction. Other residents had requested to have their meals in their rooms and this was accommodated. There was easy access to refreshments and residents were offered soup, tea, coffee and water throughout the day. The inspectors observed that catering staff were friendly and approachable and took into account the residents likes and dislikes. Resident's who spoke with the inspectors confirmed that they like the choice of meals on offer but that they could request an alternative meal if they wished. The main meal available for residents to choose from on the day of the inspection consisted of roast chicken with stuffing or a Codfish meal.

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

Capacity and capability

The inspectors found that designated centre was well-managed for the benefit of the residents who lived there. There were systems to ensure that care and services were safe and were provided in line with the designated centre's statement of purpose. This helped to ensure that residents were able to enjoy a good quality of life in which their preferences for care and support were respected and promoted. The inspectors found that the provider was working towards ensuring full compliance with the regulations however the management of fire safety risks were not robust and further actions were required to ensure the safety of residents in a fire emergency. Due to the findings in relation to fire safety in the centre the provider was issued with an urgent provider compliance plan following the inspection.

This unannounced inspection was carried out to monitor compliance with the Health Act 2007 Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 as amended. The registered provider for this centre is Nazareth Care Ireland which was developed by the Sisters of Nazareth in 2007. The registered provider took over the management and operation of this centre in October 2024 following a successful application to register as a new provider with the Chief Inspector. The provider is well established in Ireland and is involved in the management of a number of other designated centres.

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 , and two clinical nurse managers and a team of nurses. In addition, the local management team is supported by a chief nursing officer who provides regular support to the team.The team also includes health care assistants, activity staff, maintenance staff and a part-time physiotherapist. A number of key services provided by the designated centre had been outsourced such as house keeping, catering and laundry support. The registered provider maintained service levels agreements with the agencies providing these services to ensure that the services met the agreed standards.

The provider had a range of quality assurance systems in place including regular audits and clinical review of key performance indicators such as falls, wound care, nutrition and hydration. These processes were used to identify where improvements were required with action plans developed where improvements had been identified. Overall the audit processes were found to be effective however the oversight of care planning had not identified some of the findings of this inspection. These are set out under Regulation 5: Individualised assessment and care plan. Although there was local and senior management oversight of risks in the designated centre, the inspectors found that risks associated with fire safety had not been sufficiently mitigated to ensure that current evacuation procedures were effective to evacuate residents to a place of safety in the event of a fire. Furthermore, risks associated with the transportation of residents who required the use of a wheelchair did not have a risk assessment and mitigation plan in place.

There were sufficient numbers of staff available in the designated centre to provider care and support to meet the assessed needs of residents during the day. Arrangements were in place to maintain staffing levels to cover staff absences. A review of rosters confirmed that all absences had been filled. The provider was currently recruiting for a health care assistant role. The part-time role for the physiotherapist had been filled and was due to be in place in November 2024. Records reviewed on inspection, confirmed that the provider made additional staff resources available in instances where residents required additional support and supervision to meet their care needs however, inspectors were not assured that the provider had allocated sufficient numbers of staff during the night to carryout fire evacuations in a timely manner bearing in mind the dependency levels of the residents and the size of the compartments to be evacuated. As a result of the level of risk identified the inspectors requested an urgent compliance plan following this inspection in which the provider was required to set out how they intended to manage a safe evacuation of residents at night when the staffing levels were at their lowest.

The provider submitted a suitable compliance plan response post inspection, which confirmed that additional resources had been made available to ensure that there were sufficient numbers of staff available to carry out a safe evacuation in the event of a fire emergency at night.

The inspector's reviewed training records and found that there were good levels of training provided to support staff in their individual roles. The inspector's found that the majority of staff had attended mandatory training and those staff spoken with in the course of the inspection were confident in their abilities to fulfill their roles as a result of knowledge acquired at training. Nevertheless, there were two staff members who had not received their fire training in accordance with the provider's fire safety policy. However, the provider had made arrangements to ensure that those staff received the required training.

The inspector reviewed a sample of residents' contracts for the provision of services and found that contracts accurately described the service provided and the charges for the service.

A review of the complaints records and feedback from residents indicated that complaints were investigated and well managed in line with the centre's own policy and procedures. Complaints were a regular agenda item on the governance meetings and the provider was keen to learn from complaints to advance the quality of the service.

Regulation 15: Staffing

A review of the centres rosters confirmed that staffing numbers were consistent with staff numbers identified in the centre’s statement of purpose. However, inspectors found,

- There were insufficient numbers of staff available at night time to ensure residents could be evacuated to a place of safety in a timely manner in the event of a fire emergency in the designated centre.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The inspectors reviewed records relating to staff training and found :

- Two staff members required refresher training in fire safety and arrangements had already been made by the provider for those staff to receive the required training.

Judgment: Compliant

Regulation 21: Records

The inspectors found that records were maintained in line with the requirements of the regulations. Records were found to be stored securely and were made available for the inspectors to review.

Judgment: Compliant

Regulation 23: Governance and management

The provider had failed to provide the resources that were required to address the significant fire safety risks identified in their own fire safety risk assessment and compartmentation reports and recommendations from their own fire competent person. These findings are set out under Regulation 28.

The inspectors found that the registered provider had management systems in place to monitor the quality of the service provided however some actions were required to ensure that these systems were sufficient to ensure the services provided are safe, appropriate and consistent. For example:

- The oversight of evacuation drills was not sufficiently robust to provide the necessary assurances that all residents could be evacuated to a place of safety in the event of a fire emergency.
- Care plan audits did not always identify where the resident's care plan did not provide sufficient up to date information to guide staff in respect of

interventions required to meet the resident's needs.

- Some known risks had not been added to the risk register, for example the risk of injury to residents when using equipment to aid their mobility. This meant that strategies to prevent injury or harm when transporting residents using wheelchairs within the centre had not been identified.
- The oversight of fire safety precautions in the centre was not robust and did not adequately support effective fire safety arrangements.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

A review of a number of contracts for the provision of services confirmed that residents had a written contract of care that outlined the services to be provided and the fees to be charged, including fees for additional services.

Judgment: Compliant

Regulation 34: Complaints procedure

An effective complaints procedure was in place and it was displayed in a prominent place within the centre for residents and families to see. There was a nominated person to record and investigate complaints and there was information available to support residents access to independent advocacy services if required. There was a nominated review officer in place and staff had attended complaints management training.

Judgment: Compliant

Quality and safety

Residents living in this centre experienced a good quality of life and received timely support from a caring staff team. Residents' health and social care needs were met through well-established access to health care services and a planned programme of social care interventions. Overall this inspection had found the provider had made progress to address some of the known fire risks in the centre. Notwithstanding this, more focus and effort was now required to ensure that all known risks were

addressed in a timely manner.

Residents could retain the services of their own general practitioner (GP) but also has access to local GPs who visited the centre on a regular basis. There were arrangements in place for out of hours medical support. Care records confirmed appropriate referral to and review by health and social care professionals where required, for example, dietitian, speech and language therapist and chiropodist. Residents had access to specialist services such as psychiatry of old age and nurses had access to expertise in tissue viability when required. Clinical staff were able to avail of a selection of training resources including medication management to maintain their professional competence.

Clinical interventions were subject to routine audit. The provider maintained regular clinical oversight of falls, wound care, nutrition and hydration, medicine management, antibiotic use and skin care. A review of clinical, operational and environmental information was discussed during provider meetings and actions identified for improvement where necessary.

Residents' needs were comprehensively assessed using validated assessment tools at regular intervals and when changes were noted to a resident's condition. The inspector saw that residents appeared to be well cared for and residents gave positive feedback regarding their life and well-being in the centre. While there was oversight of the care planning process, the inspectors found that in some cases care interventions recorded in residents' care plans required updating to ensure that they reflected the residents' current needs and intended outcomes for the resident.

The centre's premises was clean and well laid out. Inspectors observed that the centre's internal premises were in good condition. During the walkabout of the centre the inspectors found that new flooring had been installed both in residents' rooms and in the communal areas. Corridors were well maintained and free from inappropriate storage. There was good organisation of storage facilities in the centre which promoted easy access to mobility equipment and home supplies.

The registered provider had ensured effective oversight processes were in place to ensure the sustainable delivery of safe and effective infection prevention and control measures in the centre. The allocation of suitable storage and the segregation of clinical and non-clinical items along with effective cleaning protocols meant that the provider was promoting good infection control practices in the centre.

Residents' rights were protected and promoted. Individuals' choices and preferences were seen to be respected. Residents were supported to access shopping in the local town and residents told the inspectors of the garden party that had been held recently. There was a good programme of individualised and group activities available. Residents spoken with on the day told the inspector that they were looking forward to the music session that was to be held later that day. Residents social care needs were captured as part of the admission process and reviewed with the resident from time to time. A review of activity records confirmed that trips out to local places of interest was a feature of the activity support. Some notable events included, trips to garden centres, Lough Key Forrest park and a local pet farm.

While the provider had carried out improvements and had addressed a number of fire safety risks, there was still a number of fire risks that had yet to be resolved. This was evident from a review of the providers own compartmentation survey report dated May 2024 and a fire safety risk assessment dated July 2024. Some high rated risks identified in the reports had not been resolved within the recommended time lines. These outstanding fire safety works were in respect of improving fire containment, including some fire doors, fire compartmentation around the lift lobbies in both units and fire evacuation procedures required in the absence of effective fire stopping and compartmentation.The continued delay in addressing these risks was impacting on the safety of the residents.

Furthermore the inspectors found additional fire safety risks on the day of the inspection that had not been identified by the provider.These findings are detailed further under Regulation 28: Fire Precautions.

Regulation 17: Premises

The provider had made significant progress to the overall premises of the centre. The inspectors found the premises to be in good condition and the commitments made by the provider from the previous inspection had been fulfilled.

Judgment: Compliant

Regulation 26: Risk management

The risk policy contained all of the requirements set out under Regulation 26(1). The local risk register was comprehensive and detailed. Risks were kept under review by the person in charge and were reviewed and updated on a regular basis. The risk register identified risks and included the additional control measures in place to minimise the identified risk, however the level of risk associated with evacuation of residents at night time and the use of wheelchairs in the centre was not sufficiently addressed.

Judgment: Compliant

Regulation 27: Infection control

The registered provider ensured that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority were implemented by staff. Up to date training had been provided to all staff in infection control, hand hygiene and in donning and doffing of personal

protective equipment (PPE).

Regular audits of infection prevention and control, environment and hand hygiene found good levels of compliance; the inspector also noted that staff were seen to perform good hand hygiene technique. The centre was clean and well-maintained. Effective cleaning processes were in place to support and maintain high levels of cleanliness.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider was failing to meet the regulatory requirements on fire precautions in the centre and had not ensured that residents were protected from the risk of fire.

While the provider had carried out improvements and had addressed a number of fire safety risks previously identified, there was still a number of fire risks that had yet to be resolved. These outstanding risks and additional fire risks impacted on the safety of the residents.

Day-to-day arrangements in place in the centre did not provide adequate precautions against the risk of fire.

- The inspectors noted a build-up of lint in both dryer machines located in the laundry room. This created a risk of a fire as lint is a highly flammable material.
- A plant room located in the basement had signs of being used as a storage area as various items had accumulated. As the plant room is a high risk room, storage of flammable or combustible items would create a potential fire load in this room.
- In the kitchen area, the inspectors observed a lack of an automatic suppression system or Ansul system over the cooking area. This was a condition as set out by the local fire authority at the time of the granting of the building fire safety certificate.
- From a review of a kitchen canopy and service records, the canopy had been cleaned on April 2024 and was due a clean on October 2024. As such the canopy was overdue a clean at the time of the inspection. This created a potential fire risk from the build-up of grease and grim over time.

Arrangements for the means of escape including emergency lighting required improvements. For example:

- The inspectors noted a lack of emergency lighting above a final fire exit door into the Larmier unit. This created a risk of this fire exit not being provided with adequate illumination in the event of a night time evacuation.
- Some emergency lighting throughout the centre were illuminated and some

were not. The inspectors could not be assured the system was functioning appropriately or that there was no fault with the system due to some emergency lighting staying illuminated and some not and a review of the emergency light system by competent technician was needed to confirm the system is functioning as intended.

The provider needed to improve the arrangements for maintaining the means of escape, the building fabric and the building services. For example:

- A fire exit from a chapel was obstructed by an item of furniture. This created an obstruction and a potential delayed evacuation in the event of a fire from this area.
- A set of double fire doors into the Holy Family unit had some small holes that needed attention to maintain the integrity of this fire door. Furthermore, the same double fire door did not align when closed, this compromised the effectiveness of the fire doors to contain the spread of smoke and fire.
- The door closing mechanism of another fire door into a hair salon and a shop were not connected. As the door closing mechanisms were not functioning, this created a risk of fire to spread from these rooms.
- Up-to-date quarterly and annual certificate service records for the emergency lighting system were not available on the day. As such, the inspectors could not be assured the system was being regularly serviced by a competent technician to ensure it was fully functional and in working order.

The provider had failed to adequately review fire precautions throughout the centre. For example:

- The inspector noted fire risks identified from the providers own compartmentation survey report dated May 2024 and a fire safety risk assessment dated July 2024 had not been resolved. There was no time bound action plan in place with clear actions and time frames for these risks to be addressed.

The registered provider failed to provide adequate arrangements for containment and detection of fire. For example:

- A number of glazing units along some protected corridors could not be verified to meet the required fire rating criteria as there were no specific markings or certifications to indicate the fire rating of the glazing units in question.
- The inspectors were not assured a number of fire doors throughout the centre were fitted with the required intumescent fire seals. The provider was requested to seek confirmation from the fire door manufacturer.
- The inspectors noted a soft spot in a wall within a pad store room. This required a review by the providers competent person to ensure the required fire rating was provided for in this area.

A number of high rated fire risks as identified from the provider`s own Fire Safety Risk Assessment (FSRA) had not been resolved. These risks continued to

compromise the containment measures in the centre. For example:

- The required 60 minute fire rated door had not been fitted between an oxygen room and an electrical room.
- A fire door was missing from a bathroom that had been repurposed as a store room.
- The subdivision of a store room needed upgrading to a 30 minute fire door along with the associated walls.
- 60 minute fire rated automatic lift curtains were not in place.
- A non-fire rated metal chute traversed the 60 minute fire rated first floor in the sluice rooms.
- Some basement areas still required fire stopping around penetrations. The inspector could not be sure that the fire stopping that was carried was done by a specialist fire stopping company or that the ventilation ducting had been resolved.
- From a review of the quarterly and annual servicing certificates, the fire detection alarm system was indicated as a fully addressable L1 category system, however, the inspectors noted the absence of fire detection from a number of toilets adjacent to escape routes and in residents en-suites and were not assured that these rooms were connected into the fire alarm system.
- Assurances were required in regards to the system for the detection of gas in the kitchen. Inspectors were not assured gas detection was linked to the fire alarm system. As cooking was carried out using gas, the shut off system would require staff to manually shut off the valve. The risk of a gas leak had not been assessed which could result in a gas leak going undetected if the kitchen was not occupied.
- Personal emergency evacuation plans (PEEPS) were in place for each resident but could be improved by adding special considerations for cognitive impairment, hearing, blindness and supervision after the evacuation requirements

Arrangements for evacuating all persons in the designated centre and safe placement of residents in the event of a fire emergency in the centre were not adequate. For example:

- As identified in the Fire Risk Assessment, the Compartmentation Survey and on the day of the inspection, lifts in both Larmenier and Holy Family were not lobby protected at the ground level to the bedroom accommodation and bedroom corridors. As a result, the evacuation procedure as recommended by the providers' fire consultant was to evacuate the ground and first floor compartments simultaneously into the adjoining compartments.
- While records showed that regular simulated evacuation drills were taking place, the inspectors were not assured based on the records of the drills reviewed that staff were adequately prepared for the scenarios that are likely to be encountered by them in the event of a fire in the centre.
- The evacuation times recorded to evacuate 16 residents with 5 staff members was in the region of 13 minutes. The inspectors considered this time to be excessive for the evacuation of a fire compartment and the provider needed

to reduce this time. Furthermore, some of the drills reviewed were not a realistic reflection of an evacuation as one drill stated the evacuation time would be longer if residents were involved and on ski-sheets.

- Taking into consideration the level of residents' dependency levels and the simultaneous evacuation of ground and first floor compartments with 5 staff at night, the inspectors were not assured there were; adequate supervision of the remaining residents in the centre during an evacuation with 1 staff member to supervise the neighbouring unit over two floors, to meet the fire brigade, to supervise residents in other areas of the centre and at the assembly area.
- The inspectors were not assured that adequate measures were in place to evacuate the largest compartments on the ground and first floor simultaneously with the staffing resources in a reasonable and safe manner during night time scenarios.

The provider was issued with an urgent action plan and acceptable assurances were subsequently received with two additional staff for night time evacuations.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Although care plans were reviewed and audited on a regular basis the inspectors found:

- Care plans were not always updated following a change in a resident's needs or a care plan review. For example, interventions to manage a residents responsive behaviour(How residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment.) had not been updated in their care plan when their responsive behaviours escalated.
- Some care plan interventions did not give sufficient detail to guide staff in the interventions required to meet the assessed need of the resident.For example, the care plan interventions for residents with an MDRO (Multidrug-Resistant Organism) infection were generic in construction and not specific to the individual resident and the interventions required.

Judgment: Substantially compliant

Regulation 6: Health care

The inspector found that residents had timely access to medical and allied health care professionals. There were also arrangements in place for out of hours medical

support for the residents. The registered provider ensured that there was a high standard of evidence based nursing care in accordance with professional guidelines.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Staff who spoke with inspectors had up-to-date knowledge appropriate to their roles to positively react to responsive behaviours. The staff were familiar with the residents and were knowledgeable in respect of the triggers that may cause the resident distress or anxiety. Referrals were made to specialist services in a timely manner including referrals to psychiatry of later life.

There was a restrictive practice policy in place to guide staff. Records show that when restrictive practices were implemented, a risk assessment was completed and there was a care plan in place to guide staff. Alternatives to restrictive practices were trialled in the first instance. For example the provider ensured that additional resources were made available to prioritise a resident's well-being when the resident's responsive behaviours increased the risk of harm to other residents and staff. This ensured that the least restrictive measures were put into place to manage the risks associated with the resident's behaviours and that the resident was adequately supported in order to reduce the likelihood of these events occurring.

There was a restrictive practice register in place which was reviewed on a regular basis.

Judgment: Compliant

Regulation 8: Protection

There was a clear safeguarding policy in place that set out the definitions of terms used, responsibilities for different staff roles, types of abuse and the procedure for reporting abuse when it was disclosed by a resident, reported by someone, or observed. The process included completing a preliminary screening to decide if there was a need for further information or to proceed to a full investigation, or whether there was no evidence that abuse had occurred.

The management team were clear on the steps to be taken when an allegation was reported. The staff team had all completed relevant training and were clear on what may be indicators of abuse and what to do if they were informed of, or suspected abuse had occurred.

Judgment: Compliant

Regulation 9: Residents' rights

There were arrangements in place for residents to pursue their interests on an individual basis or to participate in group activities in accordance with their interests and capacities. There was a schedule of activities in place which was available for residents to attend seven days a week. Residents also had good access to a range of media which included newspapers, television and radios.

Resident meetings were held on a regular basis and meeting records confirmed that there was on-going consultation between the staff and residents regarding the quality of the service provided.

Judgment: 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 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Nazareth House Nursing Home Sligo OSV-0000369

Inspection ID: MON-0045093

Date of inspection: 25/10/2024

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The Director of nursing has increased the staffing by 2 whole time equivalent staff at night to ensure increased supervision in the event of an emergency until the fire curtain is installed	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Training has been carried out by an external provider to ensure effective drills. • This Training was completed in November & December. • All Nursing staff including Senior Management have completed Fire Marshal training. • CNMs will have oversight of all evacuation drills on days & nights. • Each unit will complete 2 drills per month. • Additional night staff have been rostered until the fire curtain is installed to ensure increased supervision at night. • A review of the care plan audit was carried out by the Quality and compliance manager and amended to provide staff with a clear action plan related to each care plan audit in order for staff to update the care plan effectively. • A designated preceptor has been appointed to work with the nurses on their care plans to ensure compliance with the regulations. • The risk register has been updated and will be reviewed monthly by the director of nursing as well as when new risks are identified to ensure it is updated in accordance with the regulation • Please see Regulation 28 Fire Precautions below	

Care plan audits did not always identify where the resident's care plan did not provide sufficient up to date information to guide staff in respect of interventions required to meet the resident's needs.

• A review of the care plan audit was carried out by the Quality and compliance manager and amended to provide staff with a clear action plan related to each care plan audit in order for staff to update the care plan effectively.
• A designated preceptor has been appointed to work with the nurses on their care plans to ensure compliance with the regulations.

Some known risks had not been added to the risk register, for example the risk of injury to residents when using equipment to aid their mobility. This meant that strategies to prevent injury or harm when transporting residents using wheelchairs within the centre had not been identified.

• The risk register has been updated and will be reviewed monthly by the director of nursing as well as when new risks are identified to ensure it is updated in accordance with the regulation

The oversight of fire safety precautions in the centre was not robust and did not adequately support effective fire safety arrangements.

• Please see Regulation 28 Fire Precautions below

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• This system to prevent lint build-up has been reviewed and there is now a daily checklist in place to ensure lint is removed and not allowed to build up.
• All inappropriate items have been removed from the plant room and this is now part of the daily spot fire inspection.
• The Ansul suppression system is being purchased and will be installed to ensure compliancy with the regulation.
• The cleaning of the canopy only needs to be carried out annually (VSS cleaning company recommendations) as we don't fall under the cooking hours for it to be cleaned every 6 months – please see attached.
• The lack of Emergency lightening above the fire exit door has now been addressed and a new fitting with LED bulb inserted..
• An Audit has been completed on all emergency lightening 23/12/2024– results forwarded by the company over seeing this and assurance given that there is adequate and affective lightening in place. However further work is required to replace fittings and upgrade to LED bulbs and this will be completed in full.

• This item of furniture obstructing the chapel exit was removed and this exit is on the morning and evening fire checks.
• All holes in fire doors have been appropriately filled and the alignment corrected.
• The mechanism on the fire door into the hair salon has been addressed and all doors are now on a weekly checklist by the Maintenance Department
• All quarterly and annual certificates were forwarded post inspection by the DON.
• The fire risk assessment has been reviewed by the DON and the action plan is now in place.
• The Glazing Units have been fitted with appropriate fire rated glass.
• New Fire Doors have been ordered and work will commence in January.
• The area identified by the inspector is being replaced with fireboard & plaster on the week of the 13/01/2025
• 60 minute fire rated automatic lift curtains have been ordered and will be inserted week beginning 03/02/2025 – awaiting exact date from company.
• This non fire rated chute in the first floor sluice room will be removed mid January and appropriate fire damping completed.
• A review of the fire stopping by a qualified person will take place mid January and any necessary work completed and certified.
• The current L1 system is under review by Nazareth's fire management company, once this review has been completed, all recommendations will be actioned in order to ensure compliance.
• After checking with our Gas supplier – he has informed us that we have a gas detection system in the main kitchen and if there is a leakage, it will automatically shut down the valve.
• The PEEP document has been reviewed by the quality and compliance manager and this has been updated to facilitate special considerations.
• Training has been carried out by an external provider to ensure effective drills.
• The evacuation times are greatly reduced.
• The senarios now reflect the residents conditions and dependencies of said compartment.
• The Director of nursing has increased the staffing at night in both units to ensure increased supervision in the event of an emergency until the fire curtain is installed.

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:
• Care plans have been reviewed by the ADON and information inputted to reflect the needs of the residents making them more person centered.

• Further care plan training has been scheduled for all Nursing staff.

• A review of the care plan audit was carried out by the Quality and compliance manager

and amended to provide staff with a clear action plan related to each care plan audit in order for staff to update the care plan effectively.

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.	Substantially Compliant	Yellow	31/12/2024
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	30/04/2025
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure	Substantially Compliant	Yellow	30/04/2025

	that the service provided is safe, appropriate, consistent and effectively monitored.			
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	Orange	30/04/2025
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	30/04/2025
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	30/04/2025
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	30/04/2025
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/04/2025
Regulation	The registered	Not Compliant	Red	29/10/2024

28(2)(iv)	provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.			
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	31/12/2024
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	31/12/2024