



Report of a Restrictive Practice Thematic Inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

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| Name of designated centre: | Nazareth House |
| Name of provider: | Nazareth Care Ireland |
| Address of centre: | Dromahane, Mallow, Cork |
| Type of inspection: | Unannounced |
| Date of inspection: | 25 April 2024 |
| Centre ID: | OSV-0000257 |
| Fieldwork ID: | MON-0042899 |

What is a thematic inspection?

The purpose of a thematic inspection is to drive quality improvement. Service providers are expected to use any learning from thematic inspection reports to drive continuous quality improvement which will ultimately be of benefit to the people living in designated centres.

Thematic inspections assess compliance against the National Standards **for Residential Care Settings for Older People in Ireland**. See Appendix 1 for a list of the relevant standards for this thematic programme.

There may be occasions during the course of a thematic inspection where inspectors form the view that the service is not in compliance with the regulations pertaining to restrictive practices. In such circumstances, the thematic inspection against the National Standards will cease and the inspector will proceed to a risk-based inspection against the appropriate regulations.

What is 'restrictive practice'?

Restrictive practices are defined in the *Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013* as **'the intentional restriction of a person's voluntary movement or behaviour'**.

Restrictive practices may be physical or environmental¹ in nature. They may also look to limit a person's choices or preferences (for example, access to cigarettes or certain foods), sometimes referred to as 'rights restraints'. A person can also experience restrictions through inaction. This means that the care and support a person requires to partake in normal daily activities are not being met within a reasonable timeframe. This thematic inspection is focussed on how service providers govern and manage the use of restrictive practices to ensure that people's rights are upheld, in so far as possible.

Physical restraint commonly involves any manual or physical method of restricting a person's movement. For example, physically holding the person back or holding them by the arm to prevent movement. **Environmental** restraint is the restriction of a person's access to their surroundings. This can include restricted access to external areas by means of a locked door or door that requires a code. It can also include limiting a person's access to certain activities or preventing them from exercising certain rights such as religious or civil liberties.

¹ Chemical restraint does not form part of this thematic inspection programme.

About this report

This report outlines the findings on the day of inspection. There are three main sections:

- What the inspector observed and residents said on the day of inspection
- Oversight and quality improvement arrangements
- Overall judgment

In forming their overall judgment, inspectors will gather evidence by observing care practices, talking to residents, interviewing staff and management, and reviewing documentation. In doing so, they will take account of the relevant National Standards as laid out in the Appendix to this report.

This unannounced inspection was carried out during the following times:

| Date | Times of Inspection | Inspector of Social Services |
|------------------------|----------------------|------------------------------|
| Thursday 25 April 2024 | 09:30hrs to 17:30hrs | Mary O'Mahony |
| Thursday 25 April 2024 | 09:30hrs to 17:30hrs | Caroline Connelly |

What the inspector observed and residents said on the day of inspection

This was an unannounced inspection to monitor the use of restrictive practices, in the designated centre. Findings of this inspection were that management and staff had a clear commitment to providing person-centred care to residents as well as promoting their independence. Residents' in Nazareth House Nursing Home had a good quality of life, and the consensus, was that, in general, residents' rights and independence were promoted and respected. Where there were some deviations from the general experience of most residents, these will be discussed in the report. On the day of inspection the atmosphere was relaxed and care was seen to be delivered by kind and knowledgeable staff.

Nazareth House, Mallow which was set up as a nursing home in 1929 by the Sisters of Nazareth, was renovated and extended in 2018, into the current modernised, three-storey building. Resident accommodation was on the ground and first floors of the building in single, bright, personalised, fully ensuite rooms. The centre is situated on the outskirts of Drommahane village, near Mallow town, on spacious beautifully maintained grounds. It was very nicely presented externally and there was plenty parking spaces to the front of the building.

On entry to the centre, inspectors first impressions were that substantial resources had been invested in creating a high quality and beautifully decorated home for those who lived in the centre. The walls were decorated with lovely pictures and photographs of residents and of their involvement in activities, which were a lovely addition to the décor. Signage was thoughtfully chosen, to aid orientation for residents and visitors. The entrance was wheelchair accessible and led into the main reception room where there was a coffee dock for residents and visitors. Coffee mornings were facilitated here. There were two further spacious lounges, one to the right of main reception and the second beyond the main reception area. Both were beautifully decorated and had comfortable, relaxing seating in place. The assembly hall, conference room and offices were located to the left of the main reception area. In the reception area, one resident was observed to move freely around the different areas in their electric wheelchair. They said they were delighted with the freedom to circulate independently and enjoy the lovely surroundings.

The corridor to the right was decorated with shop-like frontage such as, a post office where residents could purchase stamps, a shop, a hairdressers' salon and a social club with full Sky TV facilities, as well as a stage for concerts. The hairdressers' salon had plenty of space for residents to sit and chat while waiting to have their hair done. The shop opened every morning and was run by volunteers. Residents told inspectors that they enjoyed browsing around the shop where clothes and toiletries could be purchased. The social club was an expansive room with seating areas and a 'magic table' for sensory interaction therapy for specific residents. The laundry, storage facilities, the main kitchen and maintenance rooms were located in the basement.

The inspection started with a walk around the centre with the person in charge and a clinical nurse manager. Resident accommodation was set out in five units as follows: Dromore and Holy Family each with 15 bedrooms; Brittany, Hammersmith and Larmenier with 30 bedrooms each. The Holy Family unit was specifically designated

to care for residents with a diagnosis of dementia. All units were self-contained with garden access, a dining room, day room, quiet sitting room and seating areas, sluice room, household cleaners' room, pantry, nurses' station and offices. Bedroom doors had residents' names on them and some had pictures or photographs displayed, depending on the residents' interests. Each resident had a life history booklet stored in their bedroom which was designed to give staff an insight into their lives and interests.

Inspectors spoke with most residents during the day and with up to 20 residents in more detail, to gauge their experience of living in the centre and in particular in relation to their choices, freedoms and rights. Some residents were in the process of getting up, some were relaxing, a number were walking about and others had visitors. One resident told inspectors that "staff were so welcoming" when they came to live in the centre and they went on to say "their kindness is something else". Another resident said they would like to say "if you are coming to a nursing home come to Nazareth". One man said "they would do anything for you" and they heaped praise on the person in charge and all the staff.

Breakfast was seen to be served to residents in the dining rooms and bedrooms, however the majority of residents dined in the dining rooms for their main meals. Meals were observed to be carefully presented with a selection of condiments and cloth napkins on each table. Dining rooms had a large, shaped, raised table, to accommodate those using specialised chairs, meaning that they could sit at a shared table and enjoy dining with friends. A number of choices, including home baked goods, were on offer at all meals. Residents informed inspectors that if they did not like a specific meal on the menu, they could request a different choice. Inspectors saw evidence of this on the day of inspection, as follows; there was a choice of beef stew or lamb on offer, however one resident told inspectors they were having chicken, as they did not like either of these meats. A menu on each table would have enhanced the dining experience as some residents could not remember what they had ordered the previous day. The person in charge stated that this would be addressed.

Inspectors spent some time in each of the four units in the morning and observed that suitable, varied music was playing on the large screen TV as well as newspaper reading and one to one interactions with activity staff. The centre had its own dog, Kobi, a white labradoodle, who was a great favourite with residents. He had been in the centre for three years. He walked around all areas of the centre during the day with a member of the activity staff or with residents. Residents spoke very affectionately about him and said his presence had "a calming and therapeutic" effect on them. There were a number of alternative sitting rooms and relaxation places available in the centre which were used throughout the day by various groups of residents with their visitors. There were three members of the activity staff on duty on the day of inspection and they were seen to be engaged with, and encouraging residents all day. The service was home to a small number of active residents under 65 years old. The person in charge had been successful in getting additional services for these residents such as personal assistant (PA) hours and specialist wheelchairs, to enable residents to be more independent. External agencies also supported the younger cohort. Mass was said in the chapel daily and staff were seen to assist a

large group of residents to make their way there, while another group watched on the CCTV feed on TV. In the afternoon a cheese and wine party was attended by a group of residents, in one of the large foyer areas. One resident said they had lived in France and they were delighted with the red wine and brie on offer, as it reminded them of their travels. A group of ladies were seen to prefer Baileys and said they felt "very posh" having afternoon drinks.

While there was consistency in the findings of person-centred practice, as described throughout the report, in three of the units, inspectors found that practices in the Holy Family unit were less so. This unit was accessed by key-pad access as a number of residents were at risk of absconsion and as such, was more removed from the general community. In the morning only one of the 15 residents was accompanied out of the unit to attend mass in the chapel. Staff said that residents watched it on the CCTV link to the church. Staff said that they did not have enough staff to accompany residents outside the unit. However, on the day of inspection there were adequate staff on duty in the centre to accommodate this, according to the roster seen. In the afternoon, residents from that unit also did not come out to the cheese and wine party. Inspectors also observed that there was a specific enclosed garden for this unit, however the garden was not easily accessible for residents to go out independently, if that was their wish. Additionally, dinner was served at 12md and all of the residents were seen to be finished their meal and returning to the day room at 12.40 on the day of the inspection. This did not indicate a relaxed approach to meal times and the social opportunities that a leisurely meal can present for residents' wellbeing. Notwithstanding the above findings, care planning in this unit was seen to be detailed and it was evident that staff were kind and knowledgeable. They knew residents' likes and dislikes and past histories. In particular, staff were aware of how to manage responsive behaviour, and they had put a lot of thought into developing guidelines and care plans, to support residents experiencing the behaviour and psychological symptoms of dementia (BPSD). Staff were observed to take residents for a walk around or out in wheelchairs during the afternoon.

The inspectors found that doors to the patios and gardens were unlocked around the main centre and in the other three units. Residents were seen to be out enjoying the gardens and the grounds. Staff and residents confirmed that the doors were open all year and especially in the spring and summer, for external walks and garden enjoyment. Residents spoke of the lovely sunny days spent outside with staff and relatives at garden parties, walks and barbeques. There was a novel "prompt poster" displayed where any key lock was in use. This consisted of rows of butterflies, each row representing the number to be keyed in to gain access. Residents were seen to use the lift independently also to access each floor and the gardens. The smoking hub was very popular and residents were anxious to ensure that inspectors were aware that they were hoping for a larger hub, as they wanted full cover from the rain when the six of them were there, together with the supporting HCA. The person in charge stated that this was in advanced planning. Minutes of residents' meetings evidenced these discussions.

Inspectors observed that notices were displayed encouraging residents to have their say, and to advise them about the various advocacy services available to them. Residents were supported and facilitated to maintain personal relationships in the

community. For example, they visited local shops in Mallow weekly on the "Bus connect" service, which was described as a great resource for them. Residents spoke about this, and how much they enjoyed going out. Residents told inspectors that they expected more opportunities for outings in the future, following a recent fundraising concert with Mike Denver. The local community had been very supportive and this had raised a large amount of money for the centre to buy their own bus. Staff said feedback was encouraged. An effective internal and external advocacy service was in place and this service was currently in use for a number of residents. An internal volunteer advocate was described as "exceptional" in supporting the rights of residents and they were at the forefront of ensuring residents had access to the bus, outings and so on.

There was a busy, happy atmosphere in the centre and visitors were present all day. A number of relatives spoken with said that in general there was good communication with staff, there was no problem visiting and that staff ensured residents were facilitated to go out with them whenever they requested this. They said they felt their family members were safe there and that there were no unnecessary restrictions on their freedom. The majority of residents spoken with, praised the staff for their patience, their care and respect. They loved seeing the hairdresser coming in every week and enjoyed spending time in "the great hairdressing salon", as well as engaging with staff from activities, external musicians, bingo, art, community agencies and the physiotherapist. This added a very social aspect to their lives and they looked forward to the daily events advertised around the centre.

Minutes of residents meetings were seen. Restrictive practice was discussed as well as information about the smoking hub, upcoming events and outings, the advocacy service and the complaints process. Outstanding issues from previous residents' meetings were followed up and updates were given to residents about this.

Staffing levels were sufficient to meet the needs of residents and staff training was up to date. Inspectors spoke with staff and they stated that they understood their role in facilitating and supporting the psychological and social well-being of residents, by ensuring that restrictive practices were only used when appropriate. They understood aspects of the training they had received on restrictive practices and were familiar with the policy on reducing restraint and the policy on safeguarding. They said they helped to facilitate activities, such as providing singing, outings, gardening and shopping, especially at the weekends. The person in charge, stated that they strived to improve the social lives and activities for residents, in order to provide a holistic care model.

Oversight and the Quality Improvement arrangements

The provider had a robust governance structure in place to promote and enable a quality service. The person in charge was responsible for the service on a day-to-day basis. The person, representing the registered provider, was easily accessible to the person in charge and management staff. The provider supported the service in promoting a restraint-free environment, including facilitating ongoing professional training, providing resources and staff development.

Audits to support oversight of restrictive practice included, audits on the use of restraints, such as bedrails, monthly medication audits, complaints audit, privacy and dignity, training audits and the provision of meaningful activities. Where audit outcomes identified some areas for improvement, action plans had been developed to inform improved care planning, reduce restrictive practice and enhance the social, lived experience of residents. Clinical governance meetings and staff meetings were facilitated on a monthly basis. Minutes of these provided evidence that restrictive practice was discussed and reviewed, under the umbrella of health and safety. Nonetheless, the person in charge stated that a restrictive practice committee was being considered, to ensure oversight of the best-practice initiatives in place. The input of physiotherapy was sought as part of a multi-disciplinary review of residents when bedrails were considered.

There were policies in place to underpin best practice, which were updated within the three-year time frame, set out under the regulations. These including a policy to support and promote a restraint-free environment, including guidelines on emergency use of restrictive interventions, a policy on safeguarding and a policy on the management of responsive behaviour, related to the behaviour and psychological symptoms of dementia (BPSD)

Inspectors reviewed a sample of care plans. Pre-admission assessments including residents' communication needs, and these were seen to be assessed to ensure the service was able to meet their needs. Care plans contained detailed person-centred information to direct individualised care including residents' social and recreational hobbies and interests. Residents had access to a multi-disciplinary team (MDT) to help in their assessments including assessments of restrictive practices. The MDT comprised the physiotherapist, general practitioner and old age psychiatry, when required. Documentation seen indicated that consultation and discussion was an on-going process regarding restrictive practice. A restraint risk assessment tool was used, to support best-practice in restrictive practice decision-making. Consent forms were signed by residents, and alternatives were trialled, prior to implementing any restriction. Relatives spoken with stated they were involved in decisions about the use of any form of restraint, if the resident could not participate in discussions for any reason.

At the time of inspection, restrictive practices in use included, 16 using bed rails, a secure dementia-friendly unit, 16 using low-low beds with floor mats, 1 lap belt for wheelchair positioning, two protective clothing suits and the occasional administration of psychotropic medications. Psychotropic medication usage was under constant

review; where a resident was identified as requiring any change in medicines, the GP reviewed the resident's prescription and adjusted it accordingly, in consultation with the resident. The pharmacist was described as attentive to the centre and undertook audits and medicine reviews for residents, in conjunction with the general practitioner (GP). Residents praised the GP, who came to a clinic in the centre for four hours each day. They said this was "a wonderful service" and felt it supported them to avoid going to an acute hospital, when the issue be addressed by staff in the centre.

Staff were appropriately trained in safeguarding vulnerable adults, behaviours that challenge and restrictive practices. Refresher training was scheduled to ensure all staff training remained current. Staff files contained all the required documentation. Where required, performance improvement plans (PIP) were initiated to maintain good standards and refresh elements of staff training.

Residents had access to assistive equipment, such as, wheelchairs and walking frames, to enable them to be as independent as possible. Many aspects of the physical environment encouraged independence, for example, the consistent flooring throughout, in bedrooms, hallways and communal areas. This enabled free mobility, especially for residents using walking aids, wheelchairs and so on. Good lighting and handrails on corridors, as well as in bathrooms, also facilitated easier and safer mobility.

Overall, the inspectors found that there was a positive, participatory culture in Nazareth House Nursing Home, which promoted the overall wellness of residents, while aiming to promote a person-centred, least restrictive, approach to care. Nonetheless, residents' quality of life would be enhanced by training staff in a human rights-based approach to meeting and understanding residents' needs and promoting full inclusion. Additionally revising meal times and the dining experience for residents in the Holy Family unit would enhance their lived experience.

Overall Judgment

The following section describes the overall judgment made by the inspector in respect of how the service performed when assessed against the National Standards.

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| Substantially Compliant | Residents received a good, safe service but their quality of life would be enhanced by improvements in the management and reduction of restrictive practices. |
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The National Standards

This inspection is based on the *National Standards for Residential Care Settings for Older People in Ireland (2016)*. Only those National Standards which are relevant to restrictive practices are included under the respective theme. Under each theme there will be a description of what a good service looks like and what this means for the resident.

The standards are comprised of two dimensions: Capacity and capability; and Quality and safety.

There are four themes under each of the two dimensions. The **Capacity and Capability** dimension includes the following four themes:

- **Leadership, Governance and Management** — the arrangements put in place by a residential service for accountability, decision-making, risk management as well as meeting its strategic, statutory and financial obligations.
- **Use of Resources** — using resources effectively and efficiently to deliver best achievable outcomes for people for the money and resources used.
- **Responsive Workforce** — planning, recruiting, managing and organising staff with the necessary numbers, skills and competencies to respond to the needs and preferences of people in residential services.
- **Use of Information** — actively using information as a resource for planning, delivering, monitoring, managing and improving care.

The **Quality and Safety** dimension includes the following four themes:

- **Person-centred Care and Support** — how residential services place people at the centre of what they do.
- **Effective Services** — how residential services deliver best outcomes and a good quality of life for people, using best available evidence and information.
- **Safe Services** — how residential services protect people and promote their welfare. Safe services also avoid, prevent and minimise harm and learn from things when they go wrong.
- **Health and Wellbeing** — how residential services identify and promote optimum health and wellbeing for people.

List of National Standards used for this thematic inspection:

Capacity and capability

| Theme: Leadership, Governance and Management | |
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| 5.1 | The residential service performs its functions as outlined in relevant legislation, regulations, national policies and standards to protect each resident and promote their welfare. |
| 5.2 | The residential service has effective leadership, governance and management arrangements in place and clear lines of accountability. |
| 5.3 | The residential service has a publicly available statement of purpose that accurately and clearly describes the services provided. |
| 5.4 | The quality of care and experience of residents are monitored, reviewed and improved on an ongoing basis. |

| Theme: Use of Resources | |
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| 6.1 | The use of resources is planned and managed to provide person-centred, effective and safe services and supports to residents. |

| Theme: Responsive Workforce | |
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| 7.2 | Staff have the required competencies to manage and deliver person-centred, effective and safe services to all residents. |
| 7.3 | Staff are supported and supervised to carry out their duties to protect and promote the care and welfare of all residents. |
| 7.4 | Training is provided to staff to improve outcomes for all residents. |

| Theme: Use of Information | |
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| 8.1 | Information is used to plan and deliver person-centred, safe and effective residential services and supports. |

Quality and safety

| Theme: Person-centred Care and Support | |
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| 1.1 | The rights and diversity of each resident are respected and safeguarded. |
| 1.2 | The privacy and dignity of each resident are respected. |
| 1.3 | Each resident has a right to exercise choice and to have their needs and preferences taken into account in the planning, design and delivery of services. |
| 1.4 | Each resident develops and maintains personal relationships and links with the community in accordance with their wishes. |
| 1.5 | Each resident has access to information, provided in a format appropriate to their communication needs and preferences. |

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| 1.6 | Each resident, where appropriate, is facilitated to make informed decisions, has access to an advocate and their consent is obtained in accordance with legislation and current evidence-based guidelines. |
| 1.7 | Each resident's complaints and concerns are listened to and acted upon in a timely, supportive and effective manner. |

Theme: Effective Services

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| 2.1 | Each resident has a care plan, based on an ongoing comprehensive assessment of their needs which is implemented, evaluated and reviewed, reflects their changing needs and outlines the supports required to maximise their quality of life in accordance with their wishes. |
| 2.6 | The residential service is homely and accessible and provides adequate physical space to meet each resident's assessed needs. |

Theme: Safe Services

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| 3.1 | Each resident is safeguarded from abuse and neglect and their safety and welfare is promoted. |
| 3.2 | The residential service has effective arrangements in place to manage risk and protect residents from the risk of harm. |
| 3.5 | Arrangements to protect residents from harm promote bodily integrity, personal liberty and a restraint-free environment in accordance with national policy. |

Theme: Health and Wellbeing

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| 4.3 | Each resident experiences care that supports their physical, behavioural and psychological wellbeing. |
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