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:	Moyglare Nursing Home
Name of provider:	Moyglare Nursing Home Limited
Address of centre:	Moyglare Road, Maynooth, Kildare
Type of inspection:	Unannounced
Date of inspection:	23 April 2024
Centre ID:	OSV-0000072
Fieldwork ID:	MON-0042418

About the designated centre

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

Moyglare Nursing Home is a ground-floor purpose-built nursing home with a capacity of 53 residents located on the outskirts of Maynooth, Co. Kildare. A variety of communal facilities for residents are available, and residents' bedroom accommodation consists of a mixture of 37 single and eight twin bedrooms. Some have en-suite facilities, and all have wash hand basins. It intends to provide each resident with the highest quality standards of professional nursing care and a commitment to involve residents' families in the delivery of services and continuum of care. Staff strive to work effectively with the multi-disciplinary teams who are involved in providing care and services for residents. Nursing care is provided on a 24-hour basis. The philosophy of care is to maintain the basic values which underline the quality of life, autonomy, privacy, dignity, empowerment, freedom of choice and respect for the humanity of each individual resident. Quality of life and well-being is the primary aim of health care provision within this designated centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	47

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
Tuesday 23 April 2024	08:05hrs to 17:35hrs	Geraldine Flannery	Lead
Wednesday 1 May 2024	08:00hrs to 17:00hrs	Geraldine Flannery	Lead
Tuesday 23 April 2024	08:05hrs to 17:35hrs	Helena Budzicz	Support
Wednesday 1 May 2024	08:00hrs to 17:00hrs	Helena Budzicz	Support
Wednesday 1 May 2024	07:00hrs to 17:00hrs	Manuela Cristea	Support

What residents told us and what inspectors observed

This inspection was conducted over two days. The inspectors spent time in the centre observing the care provided and talking to residents, visitors and staff to see what life was like for residents living at Moyglare Nursing Home.

From the observations of inspectors and from speaking to residents and their families, it was evident that residents were supported by kind and dedicated staff, albeit in insufficient numbers. The feedback from residents was that they were generally happy living in the centre. One resident said "staff are great, and so good to me". However, two residents also mentioned that it can be very 'noisy', and that noise was particularly evident in the evening and early mornings. Inspectors spoke with three visitors who had relatives living in the centre and they all had very positive words about the care their loved one received, with one saying 'I could not fault the care, staff are lovely', residents here are 'well looked after'.

Overall, inspectors observed that staff were very busy throughout the day. Staff did their best to maintain a calm and content atmosphere in the centre, however they did not manage this all the time, and there were intense moments when staff tried to contain and de-escalate responsive behaviours especially in the dementia unit. The staff spoken with expressed a commitment to making every effort to support the safety and welfare of residents.

Although the inspectors found that residents living in the centre gave positive feedback about the centre and were complimentary about the staff and the care provided, inspectors were not assured that effective management systems had been implemented to protect residents, particularly in relation to the provision of sufficient resources to run a safe service. Inspectors observed that there were a number of residents with high dependency needs that required additional support from staff, and this support was not always available. As a result, at various moments during the day the atmosphere in the centre was observed to be tense, chaotic with staff trying to diffuse situations where residents displayed responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment). These and other concerns will be discussed further in the report.

Inspectors observed staff coordinating the care of the residents throughout the day. Residents' independence was seen to be encouraged most of the time, for example, by encouraging residents to mobilise, eat and drink according to their ability. However, inspectors also observed instances where staff did not promote positive risk-taking behaviours and instead encouraged residents to sit down, particularly in the dementia unit. This was particularly evident at times when there was less supervision available, such as during staff breaks. The inspectors saw that the majority of residents appeared relaxed and comfortable in their home. Those residents who could not communicate their needs or wishes to the inspectors were observed to generally be content and comfortable throughout the day. But the

inspectors also observed episodes of agitation when residents did not have the required assistance available.

Overall, the inspectors observed kind and courteous interactions between residents and staff. However, there were occasions where inspectors observed institutional practices in the centre, occasions where incidents had not been recognised as safeguarding concerns and at times, staff were not consistent in their approach to those residents who presented with responsive behaviours. Other institutional practices were observed such as applying clothes protectors without seeking consent from the residents. On the notice board next to the food menu in the dementia unit, the inspectors observed a list with all residents' names unit that showed when each resident had a bowel movement. One resident stated to the inspector that they were not happy that 'everyone needs to know my business'.

The inspectors observed the lunchtime experience and found that the meals provided appeared appetising. Inspectors saw that choice of textured modified diets for residents with impaired swallowing was available and these meals were well-presented. The residents said that 'the food was lovely' and if they didn't like what was on the menu, they 'could ask for something different'. Staff were seen to assist residents in an unhurried manner. Staff and residents were seen to interact well at lunchtime, with lively chatting going on in the dining room. Some residents were seen to have their meals in their bedrooms, but the majority of residents came to the dining rooms. A variety of drinks were being offered to residents with their lunch. Residents' independence was promoted with easy access to condiments and drinks on each dining room table.

Throughout the day, inspectors saw residents relaxing in day rooms or walking outside in the courtyard. Activity schedules were displayed throughout the centre, which detailed a varied activity programme available to residents. The inspectors observed activity staff carrying out various group activities during the inspection, which were well-attended. Inspectors observed residents enjoying hand massages, aromatherapy, dancing and music, and there was lovely spontaneous group singing in the activity room. However, inspectors noted that outside of the group activities, there was very limited engagement by staff in a meaningful manner with residents who chose to stay in the bedrooms throughout the day. Most engagement with these residents was task-related, such as personal care or assistance at meal time. Inspectors noted that there were long periods of time where some residents sat in their bedrooms, with minimal opportunities for engagement and activation. Some of these residents had arrangements in place for additional support in terms of dedicated one-to-one care hours, which were not in place. One of the inspectors arrived at the centre earlier at 7 am, and observed that overnight dedicated one-to-one care hours were also not in place for more than half of the residents assessed as requiring this level of care.

On the second day of inspection, there was a suspected outbreak of Norovirus (vomiting bug) in the designated centre. The inspectors observed many examples where staff did not adhere to appropriate infection prevention and control procedures and were observed crossing between residents and between different areas of the centre, not always washing their hands in between. One staff to provide

dedicated one-to-one care to one resident had been allocated to oversee two residents in two different areas of the centre. This was despite the fact that the management plan agreed with public health stated that there should be no cross-over of staff to reduce the risk of infection spread.

Inspectors saw sufficient private and communal space for residents to relax in. Residents had easy access to an enclosed outdoor garden. Inspectors observed a wooden structure in the garden and were informed it was used as a sheltered smoking area that residents could use in adverse weather conditions. The inspectors observed it used by residents during the day and were not assured that the material used for this structure was fire retardant.

Bedroom accommodation comprised both single and multi-occupancy bedrooms. Some residents chose to personalise their rooms with items of significance, including ornaments and pictures.

Overall, inspectors saw that many aspects of the upkeep of premises required attention. Some of the bedroom furniture was dated and worn. The integrity of the structure of the building was compromised as external foliage was seen entering the building in the main reception area, and an external wooden fascia board under the roof near the main dining room appeared damaged. The inspectors observed that a number of areas of the centre were visibly unclean during the inspection and will be discussed later in the report.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre and how governance and management affect the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

The findings of this inspection were that the registered provider had failed to put effective management systems in place to ensure that the service provided was safe and the care and welfare needs of the residents were met. Fundamental improvement was required in a number of areas to achieve safe care delivery and to protect the well being of residents in the centre.

The registered provider had failed to put in place the required resources to ensure the effective delivery of care, resulting in adverse impact on residents and serious non-compliance with the regulations. Overall, there was a significant decline in the level of compliance for the designated centre.

The centre had already an attached restrictive condition to the registration to ensure that four bedrooms (30, 31, 32 and 33 in St Margaret's unit) registered for twin occupancy would only be used on a single occupancy basis until such time that they would be refurbished. The condition was attached to ensure that no existing

resident would be adversely impacted by refurbishment works that were required to register these bedrooms for twin occupancy, while at the same time ensuring that the size and layout was appropriate to support the privacy of two residents and in line with regulatory requirements. The condition required the registered provider to carry out these refurbishment works in the event of a vacancy arising in any one of these four bedrooms. The inspectors found that the registered provider had not done so and had breached this condition, by admitting a new resident into one of these beds in February 2024. Assurances were received following the inspection that refurbishment works had started in one bedroom, and this was observed on day two of the inspection.

This was an unannounced risk inspection. The purpose of the inspection was to assess the provider's level of compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2013 (as amended). In preparing for this inspection, the inspectors reviewed actions from the last inspection, the information provided by the provider and the person in charge and unsolicited information received by the Chief Inspector of Social Services.

The registered provider was Moyglare Nursing Homes Limited. The senior management team included the provider representative who worked full-time in the centre, the person in charge and clinical nurse manager.

The governance and management arrangements were insufficient to ensure effective oversight of staff practices as inspectors observed institutional practices and numerous examples of task-based practices. The registered provider did not ensure appropriate resources were in place to provide a safe service, as detailed under Regulation: 15 Staffing. This did not ensure a safe service and staff confirmed that they were often short of staff.

The annual review for 2023 was available and included a quality improvement plan for 2024. While an audit schedule was in place, it was not sufficiently robust to identify areas of non-compliance with the regulations, as found on this inspection and evidenced in this report.

Overall, the documents reviewed did not fully meet the legislative requirements including contracts of care, complaints procedures, visitors' log, directory of residents and information for residents and will be discussed under the relevant regulation.

Documents such as staff rotas were not presented to inspectors in an open and transparent format. For example, the staff rota presented initially to inspectors did not include annual leave, sick leave or swapping of duties and staff that were listed as present on the first day of inspection were not in fact working. Inspectors repeatedly requested that a copy of the worked staff rota was provided for review, and such a copy was only made available at a late stage in day one. This information showed that the number of staff in place to meet the needs of the residents was not sufficient and not in line with the staffing complement detailed in the statement of purpose and the additional resources required to provide the level of one-to-one care funded for residents living in the centre.

Inspectors acknowledge that on the second day of inspection, accurate records were provided in a timely and transparent manner. In addition, the training matrix provided to inspectors demonstrated high levels of attendance (100%) at mandatory training such as fire safety and manual handling, however not all staff were accounted for on the list.The person in charge was aware of the requirement to submit notifications to the office of the Chief Inspector of Social Services. However, inspectors learned on the day of inspection that not all notifications were submitted in line with the requirements and will be discussed further in Regulation 31.

Regulation 15: Staffing

Inspectors were not assured that the provider had the required numbers of staff available with the required skill-mix having regard to the size and layout of the centre and the assessed needs of the residents.

Where residents were assessed as requiring one-to-one supervision, this was not always provided. For example, 17 residents requiring one-to-one supervision as evidenced by documents confirming additional funding, did not all have their funded supervision arrangements in place. This adversely impacted on the quality of care and quality of life that these residents received.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff were not appropriately supervised and guided to carry out their duties to protect and promote the care and welfare of all residents. For example:

- Inspectors observed a lack of understanding and knowledge of a human rights-based approach to caring for and supporting residents' rights, and numerous institutional practices as detailed under Regulation 9: Residents' rights.
- Staff were not appropriately supervised and guided on how to provide care for residents with complex care needs, such as responsive behaviours. This is detailed under Regulation 7: Managing behaviour that is challenging.
- Inspectors observed poor adherence to infection prevention and control standards, as evidenced under Regulation 27: Infection Control, which could increase the risk of cross-contamination in all areas.

Furthermore, the training matrix provided to inspectors for review on inspection did not give a clear overview of staff training as not all staff members working in the centre were accounted for. For example, not all staff nurses working in the centre

appeared on the training matrix. Consequently, the inspectors were not assured that all staff had the appropriate training in place to support them in delivering safe care to the residents.

Judgment: Not compliant

Regulation 19: Directory of residents

The directory of residents maintained in the designated centre did not include all the information specified in paragraph 3 of Schedule 3 in the Care and Welfare of Residents in Designated Centres 2013, for example from a random selection of residents some information did not include:

- The name, address and telephone number of the resident's general practitioner (GP).
- Where the resident required transfer to hospital for treatment following an incident in the centre.
- Where the resident had died at the designated centre, the date, time and cause of death when established.

This was a repeat finding from the previous inspection.

Judgment: Not compliant

Regulation 21: Records

Information governance arrangements in the designated centre were poor and the management of records was not in line with regulatory requirements, as follows;

- A number of residents received additional funding, however there was limited information available on how this funding was allocated and utilised. The registered provider submitted additional information as requested after the inspection.
- Staffing rosters provided to inspectors on the first day of inspection were not accurate and did not reflect the worked hours. Inspectors acknowledge that this was provided at a later stage.
- The directory of visitors was not accurately maintained. It did not include all visitors going into the centre. Inspectors saw evidence of numerous professionals attending the centre to review residents as required, however no records were maintained of their visit in the visitors log.
- The training matrix available on the day of the inspection was not up-to-date as details of all employees working the centre were not included.
- The monthly financial statements were not available for each resident.

- The records for medical allergies on residents' files were not updated accurately according to the information from the discharge letter from the hospital. This posed a serious risk that critical information relevant to a resident's care would be missed.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider had failed to ensure the designated centre was adequately resourced and operated at all times in line with its statement of purpose and its conditions of registration.

- In December 2023, a condition came into effect that four bedrooms should only be used to accommodate the existing residents on a single occupancy basis. In the event of vacancies occurring in the bedrooms, which were registered as twin bedrooms, these rooms should be refurbished and reconfigured as twin rooms ensuring that each bed space complied with the regulatory revisions which came into effect on 01 January 2022. However, findings of the inspection revealed that the registered provider had breached this condition of their registration by admitting a new resident to this bedroom in January 2024.
- There were insufficient resources in place to meet the assessed needs of the residents on the day of inspection. Out of 17 residents assessed as requiring one-to-one care, only seven or eight had this support in place. There was minimal agency used and the person in charge and clinical nurse manager informed the inspector that they were actively recruiting for 12 vacancies and until then, they were exploring a number of agencies for temporary staff. However, no such service level agreement was in place at the time of inspection. This shortage of staff had a profound impact on the quality of care provided. Residents continued to be admitted to the centre during a time when there was a shortage of staff.

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

- While a comprehensive assessment was completed prior to the resident's admission to the centre for all residents, some data regarding residents' needs and care were missing. Where the resident was assessed to receive specialised one-to-one supervision care, the provider did not arrange to meet the needs of each resident based on their pre-admission assessments and discharge documentation received from the discharging facility. This did not ensure that all residents received the level of care they were assessed for and that all residents living in the centre were effectively safeguarded as a result of insufficient staffing and inadequate supervision. Management oversight for

staff training,education and supervision was inadequate, as evidenced under Regulation 16: Training and staff development.

- Pre-admission assessments of residents were not informed by the ability of the registered provider to access the resources required to meet the needs of those residents.
- Pre-admission assessments of residents were not informed by the needs of residents already living in the designated centre.
- Oversight systems for notifying the Chief Inspector of specific incidents were not effective. Since the last inspection, inspectors found that two notifications had not been submitted as required under Regulation 31: Notifications of Incidents. This was a recurring finding from previous inspections.
- The centre's own quality assurance systems had not identified and acted upon in a timely manner on a number of areas of non-compliance found by inspectors. Current arrangements for the auditing of infection prevention and control and oversight of cleaning processes, assessments and care plans, such as the 'One to one' audit, failed to identify areas for improvement Systems of supervision did not provide support to staff to carry out their duties to protect and promote the care and welfare of all residents, or ensure a rights-based approach to the provision of care. This was evidenced by staff not implementing infection prevention and control procedures as evidenced under Regulation 27: Infection control and institutionalised practices and task-based care being provided as described under Regulation 9 : Residents' rights.
- The general oversight of the physical environment and the management systems to provide assurance in respect of fire safety were insufficient. On the second morning of the inspection, inspectors noted a glove placed over the fire alarm detector in a bedroom that was undergoing refurbishment. An immediate action to remove the covering was issued to ensure that the residents were protected from the risk of fire. This was immediately 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 these records were not transparent and accurate and did not meet the regulatory requirements, for example:

- The contracts of care did not include details of care to be provided in line with funding arrangements. For example, in some of the contracts of care reviewed, the weekly fee for the services provided was either not specified or outlined, whether this fee was covered through the Fair deal arrangements, privately, or as an agreement with a third party. In addition, additional

services agreed to be provided for 17 residents with comprehensive care needs, and fees agreed to be paid by the third party were not included in the contract of care.

- The registered provider had introduced an additional 50 euro per week service charge in February 2024. However, the process of introducing the charge was not clearly documented. Inspectors were informed by the registered provider that notification was circulated on the family instant messaging system to collect a letter from the nursing home detailing the increase in fees. On the day of the inspection, there was no evidence of a signed agreement with residents or their nominated persons regarding the increase in the service charge. This was introduced in a blanket-approach manner to all residents regardless of their ability to avail of services covered by this charge. This was not in line with signed contractual obligations and will be further detailed under Regulation 9: Residents' rights.
- The monthly social service charge fees, intended for specific services, were not managed adequately. Part of these fees, for instance, was allocated to cover the cost of pastoral care services and priests attending to say Mass or last rites. However, not all residents were part of a religion with which these practices and beliefs were shared, making this allocation inappropriate. Also, laundry services were included in the social service charge fee despite this fee already being covered within the National Treatment Purchase Fund (NTPF) rate.
- Two contracts of care were not signed by the resident or the resident's representative. Several contracts reviewed were signed by the same person as a witness and 'authorised signature' person on behalf of the nursing home.

Judgment: Not compliant

Regulation 31: Notification of incidents

During the inspection, inspectors identified two notifiable incidents of alleged abuse to a resident which were not notified to the Chief Inspector as required under Schedule 4 of the regulations.

Inspectors requested these incidents to be retrospectively notified.

Judgment: Not compliant

Regulation 34: Complaints procedure

The complaints procedure and policy in place did not meet the requirements of Regulation 34 as outlined in S.I No. 628 of 2022. For example:

- The complaints log was reviewed, and while there was evidence of investigations carried out, the complainants were not always provided with a written response to inform them of the outcome of their complaint, if their complaint was upheld or not, the reason for this decision, any improvements recommended.
- The complaints policy did not include the nomination of a review officer or review process should the complainant be dissatisfied with the outcome of the complaints process.
- The complaints procedure on display in the centre did not include information on advocacy services.
- The nominated complaint and review officers did not receive suitable training to deal with complaints.

Judgment: Not compliant

Quality and safety

Inspectors were not assured that the systems in place for overseeing the quality and safety of residents' care ensured that all residents living in the centre were protected by safe practices. Insufficient staff resources impacted negatively on the provision of care for residents. Significant improvements were required across all areas and details of issues identified are set out under Regulation 5: Individual assessment and care plan, Regulation 7: Managing behaviour that is challenging, Regulation 8: Protection, Regulation 9: Residents' rights, Regulation 17: Premises, Regulation 27: Infection control and Regulation 28: Fire precautions.

Residents were provided with appropriate access to medical care. Arrangements were in place for residents to access the expertise of health and social care professionals such as occupational therapist services, speech and language and palliative care services, to name a few.

Residents' nutritional and hydration needs were met. Residents' nutritional status was assessed monthly, and health care professionals, such as dietitians, were consulted if required.

The inspectors reviewed a sample of resident's assessments and care plans and found that, in general, all assessments and care plans were completed within 48 hours following the admission of the resident to the centre. However, all care plans were pre-printed on a template and generic and did not reflect the current care needs of the residents to safely guide the staff in the delivery of care. The lack of personalized information and guidance in the care plan represents missed

opportunities for staff to provide tailored care and support to the residents, which could significantly enhance their quality of life. The impact of this finding is outlined under Regulation 5: Individual assessment and care plan.

Inspectors observed instances where residents displayed responsive behaviours, and inspectors were not assured that all appropriate actions were taken according to the centre's policy. In addition, a lack of staff knowledge on how to manage these behaviours was observed, and the care plans for responsive behaviours reviewed lacked person-centred information on how to guide staff to provide adequate care to support residents during these episodes. This is discussed in the report under Regulation 7: Managing behaviours that are challenging.

Inspectors were not assured that some residents were effectively protected and that all reasonable measures were in place to safeguard residents from abuse. Although staff had access to safeguarding training, inspectors found two incidents which had not been recognised as safeguarding concerns. For example, inspectors became aware of an allegation of neglect and a peer to peer safeguarding incident on inspection and requested that the notification be submitted retrospectively.

Residents had access to television, newspapers and telephone. Inspectors observed good participation in group activities on the day of the inspection. Nevertheless, as described in the first section of this report, the inspectors observed practices that were not person-centred and which did not ensure that residents' rights, dignity and choice were promoted at all times in the centre.

The provider maintained a written guide of 'Information for residents' which was available to all residents; however, it did not contain all relevant information as required by the regulations.

The centre's design and layout were generally suitable for its stated purpose and met residents' individual and collective needs in a homely way. However, inspectors observed that some parts of the premises required repair internally and externally, as discussed under Regulation 17: Premises. While the provider had taken some action to improve the physical environment and associated facilities to support effective infection prevention and control measures, inspectors found that areas of the premises, including the laundry, doors, and equipment for residents' use, were visibly unclean. The infection control and prevention practices, especially concerning the suspected Norovirus outbreak, were inadequate. While this outbreak was not confirmed, the practices observed increased the risk of potential cross-contamination. This is discussed under Regulation 27: Infection Control.

Furthermore, inspectors were not assured that adequate fire safety precautions had been taken to ensure that residents were safe and protected from the risk of fire. Issues related to fire precautions are detailed under Regulation 28: Fire Precautions.

Regulation 11: Visits

The registered provider had arrangements in place for residents to receive visitors, and there was adequate space for residents to meet their visitors in areas other than their bedrooms if they wished. On day one of the inspection, visits were not restricted; however, on day two, there were visiting restrictions due to a suspected Norovirus outbreak. Inspectors saw that the visiting policy reflected the Public Health guidelines issued by the Health Protection Surveillance Centre (HPSC).

Judgment: Compliant

Regulation 12: Personal possessions

Residents' clothing was laundered on-site and returned promptly. Residents had adequate storage space in their bedrooms.

Judgment: Compliant

Regulation 13: End of life

From the residents' files and nursing notes reviewed, inspectors were assured that residents approaching end-of-life care in their last days had appropriate care and comfort based on their needs, which respected their dignity and autonomy and met their physical, emotional, social and spiritual needs. The centre has established links with the palliative care team and general practitioner (GP) to ensure all comfort measures are in place.

Judgment: Compliant

Regulation 17: Premises

The registered provider did not ensure that the use of premises was appropriate to the number and needs of the residents and in accordance with its statement of purpose prepared under Regulation 3. For example, the provider continued to admit into a bedroom despite a specific restrictive condition in this respect.

The following areas of the premises did not conform to the requirements set out in Schedule 6 of the regulations:

- The external and internal premises were not well-maintained and required some repair and cleaning. For example:
    - Some residents' bedrooms had unsightly markings (including organic matter) on the walls and scuffs on the door frames.

- The premises outside the laundry were visibly unclean. The bins for waste were just underneath windows; there were used gloves and cigarette butts lying around.
- Inspectors observed damage to parts of the floor coverings in the laundry, storage wardrobes in the corridors, and staff toilet facilities.
- An external wooden fascia board under the roof near the main dining room was severely damaged, and inspectors observed a part of the tree growing through the glass roof covering the centre's lobby. This could impact the structures in place and pose a health and safety risk.

- Call-bells were missing from two communal spaces used by residents.
- Not all residents had lockable storage to store precious or private items in their respective bedrooms.

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents expressed overall satisfaction with food, snacks and drinks. Food was freshly prepared and cooked on site. Residents' dietary needs were met. Choice was offered at all mealtimes, and adequate quantities of food and drinks were provided. Residents had access to fresh drinking water and other refreshments throughout the day.

Judgment: Compliant

Regulation 20: Information for residents

The Residents' guide in respect to the designated centre did not contain the following information:

- The procedure respecting complaints did not contain all the information required by the regulation, namely the review process, including external complaints process such as the Ombudsman.

Judgment: Substantially compliant

Regulation 27: Infection control

The inspectors found that the registered provider had not ensured that some procedures were consistent with the National Standards for Infection Prevention and Control in Community Services (2018). The following findings required action:

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

- A number of washed commode inserts and urinals were found on the splash sink, rather than being stored on a designated rack within the dirty utility room. This improper decontamination practice significantly increased the risk of cross-infection.
- Some of the doors, carpets, door frames and residents' equipment, such as hoists, were visibly unclean and stained, which could increase the risk of cross-contamination.
- There were worn surfaces in the residents' rooms, on bedroom furniture and on shelving in bathrooms, which would impede effective cleaning.
- There were two washing machines in the kitchenette in the St Margaret's units. The inspectors were informed that these washing machines were used to wash residents' clothes when needed and for the kitchen towels. This arrangement posed a significant risk of environmental contamination and cross-infection.
- Inspectors observed inappropriate storage practices and unsafe segregation processes between clean and dirty items. For example, a resident's rollator was stored in the communal bathroom; residents' personal clothing was observed hanging in a storage wardrobe on the corridor which was also used to store a used linen cart and other items used for personal care. The inspectors brought it to the attention of the provider and person in charge during the first day of the inspection; however, these arrangements remained unchanged during the second day of the inspection. This posed a significant risk of transmitting a healthcare-associated infection especially during a suspected outbreak of Norovirus in the centre.
- Inspectors observed that the alginate laundry bags were stored in the 'clean' part of the laundry. This meant that the carers were coming to get the bags from the laundry while attending care for residents with suspected infection. This practice posed a significant risk of cross-contamination.
- Inspectors observed barriers to effective hand hygiene practice. There was no easy access to clinical hand hygiene sinks. Alcohol hand gel dispensers were observed in the centre however, they were not always readily available at point of care for staff to sanitise hands. This reduces the spread of infection between residents. Alcohol hand gel toggles were not observed to be in use. Furthermore, the sink in the treatment room was not compliant with the required specifications.
- The laundry was visibly unclean and there were items such as mops and residents' shoes lying on the floor. In addition, part of the floor was damaged, which did not support effective cleaning.
- The management of nebuliser masks used for medication administration was not adequate as a number of these were observed to be visibly unclean, which posed a health and safety risk.

- Staff did not consistently adhere to standard infection prevention and control procedures. The inspectors observed staff placing soiled linen on the floor, and then carrying it in their hands, directly next to their uniform. This posed a significant risk of cross-infection.

Judgment: Not compliant

Regulation 28: Fire precautions

Notwithstanding the proactive focus on fire safety in the centre as a result of implementing action plans arising from the previous inspection of the centre, some fire safety risks had not been identified, for example:

Arrangements for containment and detection of fire in the designated centre were not sufficient;

- There were some areas where services such as pipes and electrics penetrated the walls. There was a large gap around those penetrations, which could potentially impact the containment of fire and smoke in the event of a fire emergency. The kitchen door leading to the dining room was routinely supported by the waste bin and kept wide open during residents' meal times. In addition, this door did not have an intumescent strip.
- A fire detector was found covered in a resident's bedroom on the second day of the inspection. An immediate action plan was given and this was rectified on the day of inspection.

In addition the registered provider did not ensure adequate fire precautions were in place in all areas. For example:

- The smoking shed in the garden was not fire-rated. It was a wooden construction and some residents used a rattan chair while smoking.
- Inspectors observed discarded cigarette butts lying around in the garden and behind the laundry.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

The inspectors observed that action was required to ensure care plans were developed and reviewed in line with the assessed needs of the residents. For example;

- From the records reviewed, inspectors were not assured that all assessments and care plans were reviewed on a four-monthly basis as per regulatory requirements. Although some of the care plans were evaluated on a four-monthly basis, they were not updated to reflect residents' changing needs and therapeutic interventions. In addition, not all assessments were used in accordance with their purpose. For example, a dementia assessment was completed for a resident who was not diagnosed with dementia or dementia-associated cognitive impairment.
- There were 17 residents in the centre on the days of the inspection with complex care needs. While the majority of these residents had the 'one on one enhanced' assessment and care plans completed, they were pre-printed and generic, and they did not contain all information received from the referring service when the resident was admitted into the centre. In addition, these assessments did not detail how many hours of specialised 'one on one' care these residents were assessed as requiring, or details of the complex care needs and the interventions required to guide the staff to provide this level of care. The observation of care delivery to these residents during both days of the inspection did not provide evidence that adequate care was being provided to all residents.
- Adequate and full information was not recorded in several resident care plans to effectively guide and direct the care of residents colonised with MDROs (Multi drug resistant organisms) or any other infectious diseases. This posed a significant health risk both to the care staff and other residents.
- The medication management care plan did not include important information such as specific allergies to medications.
- The safeguarding care plans were not completed for all residents who were vulnerable due to their diagnosis or condition or for residents who had been involved in safeguarding incidents. This meant that staff were not aware of the protective measures in place to protect the residents and prevent recurrence.

Judgment: Not compliant

Regulation 6: Health care

Residents had access to regular medical reviews by a general practitioner (GP). There was evidence from the resident's files that the residents received a review by various health and social care services, such as physiotherapy and occupational therapy (OT), dietician and speech and language therapist (SALT).

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Residents who displayed responsive behaviour had care plans in place; however, the care plans were generic and did not provide sufficient information about residents' triggers, behavioural patterns or how to adequately guide staff practice to safely interact with residents and to support them during these episodes and on how to prevent re-occurrence of further responsive episodes.

While behaviour observation charts, such as ABC (Antecedent, Behaviour, Consequence) charts and Cohen Mansfield assessment were in place, they were not completed regularly, and there was no evidence that the results and findings from these assessments were appropriately analysed and used for further therapeutic plans and care plan interventions.

Judgment: Not compliant

Regulation 8: Protection

The registered provider failed to take reasonable measures to protect residents from abuse and to provide for appropriate and effective safeguards to prevent abuse in line with the National Policy for Safeguarding Vulnerable Person at Risk of Abuse 2014, as evidenced by:

- There were insufficient staffing resources to meet the assessed needs of a number of residents, some of whom had responsive behaviours or advanced dementia. This meant, that in the absence of effective supervision and support, other residents were vulnerable to escalating behaviours or abuse. Inspectors observed several examples where one resident entered another resident's room and there were no staff available to supervise or redirect.
- Incidents discovered on inspection had not been recognised as safeguarding concerns. For example, inspectors became aware of an allegation of abuse and a peer to peer safeguarding incident on inspection.
- The provider did not ensure that each staff had valid An Garda Siochana vetting clearance from the National Vetting Bureau prior to commencing employment. For example, a staff attending the centre on a trial basis had not obtained vetting clearance.
- Inspectors were not assured that all staff had completed safeguarding training, as not all staff were accounted for on the training matrix provided on day of inspection.

Judgment: Not compliant

Regulation 9: Residents' rights

The registered provider did not ensure that residents' rights were being upheld at all times, as evidenced by the following;

- From the documentation reviewed, inspectors were not assured that all residents had a choice, and their consent was sought and documented in respect of the additional social charges introduced by the provider since February 2024. These charges were applied also to the residents that were admitted to the centre prior this date and in the absence of revised contractual arrangements.
- Action was required to ensure that all residents were provided with opportunities to participate in activities in accordance with their interests and capacities. Inspectors found that for residents who predominantly spent time in their bedrooms, there was limited input from staff in terms of meaningful occupational engagement. In some instances where one to one care should have been in place, staff were observed standing in front of residents' room and not spending time actually engaging with the resident. Inspectors observed that one resident who did not speak English was left in the room by themselves all day, with no staff seen to attend to the individual resident's social needs for recreation throughout the inspection. Staff interaction was observed to be predominantly task-oriented, centred around activities of daily living and lacked meaningful engagement. Residents were seen to spend long periods of time in their rooms, with limited stimulation other than music or television playing in the background.
- Institutionalised practices were observed such as the communal use of some under-garments. There was no labelling system in operation to identify which resident they belonged to, and this collective use of personal garments did not ensure residents' dignity was preserved.
- The absence of call-bells from two communal spaces in the centre meant that residents did not have the opportunity to seek help if required or exercise choice at all times.
- Residents were being administered their medications during lunch, which did not support their right to enjoy their meals without being disturbed.
- During the first day of the inspection, inspectors saw surveillance monitors in use to monitor residents with responsive behaviours in their bedrooms. One of the monitors was positioned in active monitoring mode on the handrail in the corridor during the day. There was no evidence that consent for the monitor use was sought from the resident or their resident's representative. These arrangements did not support residents' rights to privacy and dignity and were not in line with local policy.

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 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Moyglare Nursing Home OSV-0000072

Inspection ID: MON-0042418

Date of inspection: 01/05/2024

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.To further strengthen our management structure, our original CNM 1 is now CNM 2. We have performed an internal competition and appointed CNM 1.

2. Residents' dependency levels were calculated using Rhys Hearns to determine the correct staffing ratio. This will be used to appropriately determine the number of staff to ensure the effective and safe delivery of care to the residents. Furthermore, the calculation of Rhys Hearns will be completed by the CNM2 every quarter to capture changes in the needs/dependencies of the residents. The report will be reviewed by the PIC and RPR for skill mixing and forecasting recruitments. Furthermore, staff resignations, staff vacancies due to annual leave, long-term sick leaves, and other forms of leave will be considered in the review.

3. The current service requirements for residents requiring one-to-one supervision are covered by regular /management. This includes new admission of residents with approved funding of 1:1 supervision, this will be ensured before their admission to the nursing home. The RPR has a standing service-level agreement with 2 registered staff agencies to continuously support the service requirement of the center.

4.Local and overseas recruitment for staff in progress with focus on experience working in clinical settings. The Centre is supported by a registered recruitment agency covered by service-level agreements. This will be supported by specific training in the areas of behavioral management, infection control, nutrition, safety, fire manual handling, and safeguarding in Moyglare Nursing Home.

Person(s) Responsible: Registered Provider Representative, Person in Charge, and Clinical Nurse Managers.

Timeframe: August 30, 2024

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

1. Specific training for all staff of Moyglare Nursing Home on a human rights-based approach for all staff using the HIQA Human Rights Based Approach in Health and Social Care Services will be adopted. This will be incorporated and recorded in the staff training matrix. Furthermore, training days between 3-4 pm Mon-Tues-Thurs-Fri will be allocated to effectively implement the logistics of training.

2. Specific training for all staff of Moyglare Nursing Home on the use of restrictive practices, including prevention and alternatives. This will be incorporated in the staff training matrix and facilitated in weekly in-service education of the center.

3. All assessments should identify the physical, medical, psychological, emotional, social, and environmental issues that may contribute to the use of restrictive practices. Evidence of reviews will include less restrictive alternatives or when restraints are used only as a last resort and for a shorter period. This is to support all staff in knowing the residents' needs and preferences. This will be incorporated and recorded in the staff training matrix. Additionally, managing responsive behaviors training will be provided.

4. Infection Control Training for all staff will be implemented. This will be supported by weekly in-service education to be facilitated by CNM2 focusing on hand hygiene, decontamination and cleaning of equipment, the use of PPEs, and appropriate disposal of clinical and non-clinical waste. In addition, for monitoring purposes, weekly environmental audits including staff practices to be carried out by CNM 1 and the results will be reviewed by PIC.

5. The database on the Staff Training Matrix will be reviewed to ensure all staff working in the nursing home are appropriately recorded with their training, date of completion, and expiry. This will be reviewed and updated by CNM1 and PIC every 3 months. This will also include the scheduling of re-training for staff.

Person(s) Responsible: Registered Provider Representative, Person in Charge, and Clinical Nurse Managers.

Timeframe: August 30, 2024

Regulation 19: Directory of residents	Not Compliant

Outline how you are going to come into compliance with Regulation 19: Directory of residents:
1. The Residents Directory was reviewed and updated to ensure all information is recorded by the PIC.

• The name, address, and telephone number of the resident's general practitioner (GP).
• Where the resident required transfer to the hospital for treatment following an incident in the centre.
• Where the resident had died at the designated centre, the date, time, and cause of death when established.

2. The Residents Directory to ensure appropriate details of residents' date of birth, address of resident's representative, and GP are monitored continuously, monthly audit will be conducted by the Person in charge and/or Clinical Nurse Manager. This will also include all new admissions and details of medical transfers of residents transferred to acute hospital and their return date.

Person(s) Responsible: Registered Provider Representative, Person in Charge, and Clinical Nurse Managers.

Timeframe: June 30, 2024

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
1. A specific folder will be generated to record each resident with additional funding. This will be kept and maintained by the Registered Provider Representative.

2. The duty rosters will include the names of the regular staff and 1:1 staff for residents with specialized care needs. This will be regularly reviewed by the PIC.

3. A designated signing book for residents' External Professional Service provider visitors will be placed in the reception. That will keep track of the visitors on site, their identity, the company they represent, who they came to visit, the purpose of coming in, contact details, time in and time out.

4. The training matrix will be reviewed by the PIC together with the CNM every month, ensuring all staff members' names are recorded, their training dates, and expiries, and forecasting the schedules of their training. The training matrix records, and attendance sheets will be kept in a folder.

5. The Registered Provider Representative will ensure all records of up-to-date financial

records/statements of the residents are kept and maintained. This will be archived in a separate folder.

6. All records of resident allergies in the resident files will be recorded and updated in the Resident's medication records, baseline information, and resident transfer letters (Nursing Home transfer to A & E), transfer documents, and referral forms. The CNM's will review all resident documents prepared before their medical transfers to acute hospitals or medical consultations.

7. As an oversight mechanism, the CNM's and PIC will review the records of new residents

8. The CNM's will review all resident documents prepared before their medical transfers to acute hospitals or medical consultations.

Person(s) Responsible: Registered Provider Representative, Person in Charge, and Clinical Nurse Managers.

Timeframe: August 30, 2024

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. The Registered Provider Representative will send documents regarding the completion of refurbished twin rooms to HIQA.

2. Residents requiring one-to-one supervision will be covered by regular / agency staff. This includes new admission of residents with approved funding of residents with 1:1 supervision, this will be ensured before their admission to the nursing home.

3. Local and overseas recruitment for staff in progress, this is to fully complement the staffing requirements of the centre,

4. Registered Provider Representative will hold documents of service level agreements in the designated centre for agency, local recruitment, and international recruitment companies to ensure that recruitment is in progress to address the staff vacancies.

5. All residents to receive specialized one-to-one care will be indicated in the comprehensive assessments and care plans. This will be indicated in the pre-admission assessments and in each resident's folder.

6. Specific training will be provided to staff in relation to managing responsive

behaviours, infection control prevention, the use of restrictive resources, and resident rights.

7. Access to staffing resources is fully complemented by a regular /l agency continuously. Active local and international recruitment of nurses is in progress.

8. Staff training plans will be implemented and prioritized to ensure the delivery of safe care services.

9. All notifications of incidents will be reported to HIQA by the Person in charge. All incident reports generated weekly/monthly will be reviewed. To include any gaps in the immediate treatment/interventions provided to residents. A monthly resident incident reports will be generated.
Person(s) Responsible: Registered Provider Representative, Person in Charge, and Clinical Nurse Managers.

Timeframe: September 30, 2024

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. The resident's contract of care will be reviewed and updated by the Registered Provider Representative. The weekly fee for the services will be incorporated. Additional services and funding sources will be outlined for residents with specialized care. An addendum to contracts will be generated and communicated to the residents.

2. The RPR will maintain the process when contracts are updated or changed and details of how residents are consulted and supported when fees are increased. These are now incorporated into the new Resident's contract with the centre. These include any changes to fees will be managed, consulted, and communicated to the residents.

3. The Registered provider will provide the opportunity to residents to either agree or disagree in availing of any additional services not covered by the Nursing Home Support Scheme.

4. The Registered Provider Representative will ensure the support and arrangements needed for residents who may not have the capacity to make informed decisions regarding additional charges, to access independent advocacy services to assist them in informed decision-making

5. All resident contracts will be reviewed and updated by the Registered Provider Representative specific to fees covered and not covered by NTPF will be detailed

comprehensively.

6. The Registered Provider Representative will ensure that all resident's contracts will be signed by the resident or the resident's representative.

Person(s) Responsible: Registered Provider Representative
Timeframe: August 30, 2024

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
1. All notifications of incidents will be reported to HIQA by the Person in charge.

Person(s) Responsible: Person in-charge and Clinical Nurse Managers

Timeframe: June 30, 2024

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
1. All complaints in the register will be reviewed by the PIC to ensure that a written response is indicated in the outcome of their complaints including the reason for this decision and any improvements required to prevent the occurrence of the complaints.

2. The CNM2 is now appointed as the Complaints Officer, the PIC is the Review Officer.

3. A new display in the center will be implemented including the name of the Advocacy Service representative. The Complaints Policy will be updated by the PIC.

4. The Complaint and Review Officer will undergo specific training in dealing with complaints. This will be incorporated into the training matrix.

Person(s) Responsible: Registered Provider Representative, Person in-charge and Clinical Nurse Managers

Timeframe: July 30, 2024

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The external and internal premises were not well-maintained and required some repair and cleaning. For example:

Some residents' bedrooms had unsightly markings (including organic matter) on the walls and scuffs on the door frames.

1. Refurbishment plans such as re-painting and plastering will be implemented by the RPR.

The premises outside the laundry were visibly unclean. The bins for waste were just underneath windows; there were used gloves and cigarette butts lying around.

2. Cleaning and removal of waste will be implemented by the RPR.

Inspectors observed damage to parts of the floor coverings in the laundry, storage wardrobes in the corridors, and staff toilet facilities.

3. This has already been refurbished by the maintenance team of the centre.

An external wooden fascia board under the roof near the main dining room was severely damaged, and inspectors observed a part of the tree growing through the glass roof covering the center's lobby. This could impact the structures in place and pose a health and safety risk.

4. This has already been refurbished by the maintenance team of the centre.

Call-bells were missing from two communal spaces used by residents.

5. Replaced by new call bells. Residents call bell register audit will be implemented to ensure that all residents call bells are present and operational.

Not all residents had lockable storage to store precious or private items in their respective bedrooms.

6. This is part of the refurbishment plans to be put in place by the RPR.

7. An environmental audit will be carried out by the PIC. Reports will be directly discussed to RPR.

Person(s) Responsible: Registered Provider Representative, Person in charge, and Clinical

Nurse Managers

Timeframe: September 30, 2024

Regulation 20: Information for residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 20: Information for residents:
1. The Complaints policy will be reviewed to ensure all information is included as required by the regulation concerning the review process, and external complaints process such as the referral to the Ombudsman.

Person(s) Responsible: Registered Provider Representative, Person in charge, and Clinical Nurse Managers

Timeframe: August 30, 2024

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
A number of washed commode inserts and urinals were found on the splash sink, rather than being stored on a designated rack within the dirty utility room. This improper decontamination practice significantly increased the risk of cross-infection.

1. The appropriate storage of commodes inserts and urinals will be included in the regular infection control audit.

Some of the doors, door frames, and residents' equipment, such as hoists, were visibly unclean and stained, which could increase the risk of cross-contamination.

2. Equipment cleaning and decontamination checklist will be in place, and designated staff will be assigned to clean equipment. This will be monitored by the infection control audit.

3. Doors and doorframes and carpets will be cleaned or replaced. An environmental audit will be carried out by PIC, reports will be given to RPR by the PIC. Reports will be given directly to RPR.

There were worn surfaces in the residents' rooms, on bedroom furniture and on shelving in bathrooms, which would impede effective cleaning.

4. Refurbishment plans will be put in place by Registered Provider Representative in all areas in the center.
5. Environmental audit will be carried out by the PIC. Reports will be given directly to RPR.

There were two washing machines in the kitchenette in the St Margaret's units. The inspectors were informed that these washing machines were used to wash residents' clothes when needed and for the kitchen towels. This arrangement posed a significant risk of environmental contamination and cross-infection.

6. The 2 washing machines were not used to wash the resident's clothes, it is designated to wash tea towels. This was explained to inspectors on the day of inspection. A clear sign will be in place.

Inspectors observed inappropriate storage practices and unsafe segregation processes between clean and dirty items. For example, a resident's rollator was stored in the communal bathroom; residents' personal clothing was observed hanging in a storage wardrobe on the corridor which was also used to store a used linen cart and other items used for personal care. The inspectors brought it to the attention of the provider and person in charge during the first day of the inspection; however, these arrangements remained unchanged during the second day of the inspection. This posed a significant risk of transmitting a healthcare-associated infection especially during a suspected outbreak of Norovirus in the centre.

7. De-cluttering, disposal of unnecessary items, and re-arrangements of the storage system in centre is in progress. An environmental audit will be carried out by the PIC. Reports will be given directly to RPR.

Inspectors observed that the alginate laundry bags were stored in the 'clean' part of the laundry. This meant that the carers were coming to get the bags from the laundry while attending care for residents with suspected infections. This practice posed a significant risk of cross-contamination.

8. Alginate will be stored appropriately in a working trolley used by staff daily in the units. Storage of PPEs, materials for decontamination and cleaning, and materials used for appropriate disposal of clinical and non-clinical waste will be included in the Infection Control Audit. Staff training will be included under infection control.

Inspectors observed barriers to effective hand hygiene practice. There was no easy access to clinical hand hygiene sinks. Alcohol hand gel dispensers were observed in the centre however, they were not always readily available at point of care for staff to sanitise hands. This reduces the spread of infection between residents. Alcohol hand gel toggles were not observed to be in use. Furthermore, the sink in the treatment room was not compliant with the required specifications.

9. All resident's rooms will be fitted with Alcogel dispensers. If residents are at risk of ingesting due to their medical conditions, this will be removed and replaced with toggle hand hygiene sanitizers to be issued and carried by staff members.

The laundry was visibly unclean and there were items such as mops and residents' shoes lying on the floor. In addition, part of the floor was damaged, which did not support effective cleaning.

10. The laundry room was clean, and schedules of cleaning were in place to be carried by staff. This was decluttered and items were disposed of appropriately. Environmental and Infection control audits will be carried out regularly in all areas by CNMs and PIC.

The management of nebuliser masks used for medication administration was not adequate as a number of these were observed to be visibly unclean, which posed a health and safety risk.

11. PIC and CNMs have addressed the nurses specific to regular cleaning of nebulizer masks after or when not in use. Further to this, a special container will be procured for each resident to store the nebulizer mask when not in use. This will be included in the infection control audit.

Person(s) Responsible: Registered Provider Representative, Person in charge, and Clinical Nurse Managers
Timeframe: July 30, 2024

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: Notwithstanding the proactive focus on fire safety in the centre as a result of implementing action plans arising from the previous inspection of the centre, some fire safety risks had not been identified, for example:

Arrangements for containment and detection of fire in the designated centre were not sufficient;

There were some areas where services such as pipes and electrics penetrated the walls. There was a large gap around those penetrations, which could potentially impact the containment of fire and smoke in the event of a fire emergency. The kitchen door leading to the dining room was routinely supported by the waste bin and kept wide open during residents' mealtimes. In addition, this door did not have an intumescent strip.

1. Gaps were sealed already by the maintenance team of the centre
2. The waste bin has been removed and is no longer used as a prop.
All staff have been informed and door is a swing close door and no prop is to be used to

keep it open
3. The kitchen fire door has an intumescent strip in place.

A fire detector was found covered in a resident's bedroom on the second day of the inspection. An immediate action plan was given, and this was rectified on the day of inspection.

4. Advice was given to the maintenance team when undertaking repairs not to cover the fire detectors. Despite the reason that it was covered to prevent triggering the fire alarm. Alternatives should be provided such as opening the windows to release the any unwarranted smoke generated during repairs and refurbishments.

In addition, the registered provider did not ensure adequate fire precautions were in place in all areas. For example:

The smoking shed in the garden was not fire-rated. It was a wooden construction, and some residents used a rattan chair while smoking.

5. The smoking shed will be made fire compliant by the maintenance team. This is part of the refurbishment plans

Inspectors observed discarded cigarette butts lying around in the garden and behind the laundry.

6. Regular cleaning and designated cigarette trash bins and designated smoking areas for residents and staff are now in place. This will be covered by the environmental audit tool to be implemented by the PIC. Results will be directly addressed and discussed to RPR.

Person(s) Responsible: Registered Provider Representative, Person in charge, and Clinical Nurse Managers

Timeframe: August 30, 2024

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
From the records reviewed, inspectors were not assured that all assessments and care plans were reviewed on a four-monthly basis as per regulatory requirements. Although some of the care plans were evaluated on a four-monthly basis, they were not updated to reflect residents' changing needs and therapeutic interventions. In addition, not all

assessments were used in accordance with their purpose. For example, a dementia assessment was completed for a resident who was not diagnosed with dementia or dementia-associated cognitive impairment.

1. The clinical team will review all resident assessments and care plans. Specific allocations were given to each nurse. The completion will be monitored by the CNM's.

2. All assessments will have appropriate care plans

3. The care plans will be tailored fit, to include therapeutic interventions, inputs from MDT approach, and other supportive plans.

4. All care plans will be evaluated every 4 months. The completion of the evaluations will be monitored by an audit.

5. To include evaluation, MDT approach, and supportive plans in response to the changing needs of the residents.

6. Assessment and Care plan Audit tool will be implemented. Guidance to the nurses will be facilitated by CNM's and PIC.

7. Monitoring of compliance will be done in the audit mechanism.

There were 17 residents in the centre on the days of the inspection with complex care needs. While the majority of these residents had the 'one on one enhanced' assessment and care plans completed, they were pre-printed and generic, and they did not contain all information received from the referring service when the resident was admitted into the center. In addition, these assessments did not detail how many hours of specialized 'one on one' care these residents were assessed as requiring, or details of the complex care needs and the interventions required to guide the staff to provide this level of care. The observation of care delivery to these residents during both days of the inspection did not provide evidence that adequate care was being provided to all residents.

8.All care plans and details of residents with complex care needs will be updated to ensure all information, level of care needs and hours will be incorporated

Adequate and full information was not recorded in several resident care plans to effectively guide and direct the care of residents colonized with MDROs (Multi-drug resistant organisms) or any other infectious diseases. This posed a significant health risk both to the care staff and other residents.

9. Antibiotic stewardship and resident antibiotic usage will be incorporated into the care plans (specific antibiotic care plans).

The medication management care plan did not include important information such as specific allergies to medications.

10. The medication care plan of all residents will be reviewed to include information on specific allergies to medications.

The safeguarding care plans were not completed for all residents who were vulnerable due to their diagnosis or condition or for residents who had been involved in safeguarding incidents. This meant that staff were not aware of the protective measures in place to protect the residents and prevent recurrence.

11. Safeguarding care plans will be created for residents who have been involved in safeguarding incidents. MDT and communication approach will be provided to staff to ensure information on protective measures and guide them to prevent recurrence.

Person(s) Responsible: Person in charge, Clinical Nurse Managers and Staff Nurses

Timeframe: September 30, 2024

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
From the records reviewed, inspectors were not assured that all assessments and care plans were reviewed on a four-monthly basis as per regulatory requirements. Although some of the care plans were evaluated on a four-monthly basis, they were not updated to reflect residents' changing needs and therapeutic interventions. In addition, not all assessments were used in accordance with their purpose. For example, a dementia assessment was completed for a resident who was not diagnosed with dementia or dementia-associated cognitive impairment.

1. The clinical team will review all resident assessments and care plans. Specific allocations were given to each nurse. The completion will be monitored by the CNM's.

2. All assessments will have appropriate care plans

3. The care plans will be tailored fit, to include therapeutic interventions, inputs from MDT approach, and other supportive plans.

4. All care plans will be evaluated every 4 months. The completion of the evaluations will be monitored by an audit.

5. To include evaluation, MDT approach, and supportive plans in response to the changing needs of the residents.

6. Assessment and Care plan Audit tool will be implemented. Guidance to the nurses will be facilitated by CNM's and PIC.

7. Monitoring of compliance will be done in the audit mechanism.

There were 17 residents in the centre on the days of the inspection with complex care needs. While the majority of these residents had the 'one on one enhanced' assessment and care plans completed, they were pre-printed and generic, and they did not contain all information received from the referring service when the resident was admitted into the center. In addition, these assessments did not detail how many hours of specialized 'one on one' care these residents were assessed as requiring, or details of the complex care needs and the interventions required to guide the staff to provide this level of care. The observation of care delivery to these residents during both days of the inspection did not provide evidence that adequate care was being provided to all residents.

8.All care plans and details of residents with complex care needs will be updated to ensure all information, level of care needs and hours will be incorporated

Adequate and full information was not recorded in several resident care plans to effectively guide and direct the care of residents colonized with MDROs (Multi-drug resistant organisms) or any other infectious diseases. This posed a significant health risk both to the care staff and other residents.

9. Antibiotic stewardship and resident antibiotic usage will be incorporated into the care plans (specific antibiotic care plans).

The medication management care plan did not include important information such as specific allergies to medications.

1. The medication care plan of all residents will be reviewed to include information on specific allergies to medications.

The safeguarding care plans were not completed for all residents who were vulnerable due to their diagnosis or condition or for residents who had been involved in safeguarding incidents. This meant that staff were not aware of the protective measures in place to protect the residents and prevent recurrence.

2. Safeguarding care plans will be created for residents who have been involved in safeguarding incidents. MDT and communication approach will be provided to staff to ensure information on protective measures and guide them to prevent recurrence.

Person(s) Responsible: Person in charge, Clinical Nurse Managers and Staff Nurses

Timeframe: September 30, 2024

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
There were insufficient staffing resources to meet the assessed needs of a number of residents, some of whom had responsive behaviours or advanced dementia. This meant, that in the absence of effective supervision and support, other residents were vulnerable to escalating behaviours or abuse. Inspectors observed several examples where one resident entered another resident's room and there were no staff available to supervise or redirect.

1. Appropriate staffing and training requirements will be put in place. Daily observations of staff practices will be observed by the CNM to ensure guidance and supervision. Weekly audits will be given to PIC for review. Specific audit tools will be used.

Incidents discovered on inspection had not been recognised as safeguarding concerns. For example, inspectors became aware of an allegation of abuse and a peer-to-peer safeguarding incident on inspection.

2. All incidents involving allegations of abuse will be investigated by PIC, NFO6 will be submitted and PSF1, safeguarding plans to minimize the risk and prevent the re-occurrence will be created. Communication with staff will be facilitated through handovers, weekly MDT, and meetings

The provider did not ensure that each staff had valid An Garda Siochana vetting clearance from the National Vetting Bureau prior to commencing employment. For example, a staff attending the centre on a trial basis had not obtained vetting clearance.

3. All staff working in the centre should have their Garda vetting processed before their commencement of employment. This will be facilitated by RPR and PIC.

Inspectors were not assured that all staff had completed safeguarding training, as not all staff were accounted for on the training matrix provided on the day of inspection.

4. The safeguarding training matrix will be fully reviewed by the PIC, and safeguarding staff training will be implemented.

Person(s) Responsible: Person in charge, Clinical Nurse Managers and Staff Nurses

Timeframe: September 30, 2024

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: From the documentation reviewed, inspectors were not assured that all residents had a choice, and their consent was sought and documented in respect of the additional social charges introduced by the provider since February 2024. These charges were applied also to the residents that were admitted to the centre prior this date and in the absence of revised contractual arrangements.

1. The Registered Provider Representative will review all the social charges implemented. If social charges are implemented, RPR will facilitate participation and ensure residents have appropriate information about any charges for services not covered by NHSS.

2. Social charges will only be applied to new residents under the new revised residents' contracts.

3. The residents and/or family will be allowed to give their concerns, considerations, and opinions whether they agree or not. General resident's family meetings or individual will be facilitated by the RPR.

4. Adequate written notice (30 days period) will include the rationale for any fee increase. This allows residents and their representatives sufficient time to understand the practical implications of the proposed fee change. The notice period should also give residents and their representatives a reasonable opportunity to ask questions relating to the fee changes.

Action was required to ensure that all residents were provided with opportunities to participate in activities in accordance with their interests and capacities. Inspectors found that for residents who predominantly spent time in their bedrooms, there was limited input from staff in terms of meaningful occupational engagement. In some instances where one to one care should have been in place, staff were observed standing in front of residents' room and not spending time actually engaging with the resident. Inspectors observed that one resident who did not speak English was left in the room by themselves all day, with no staff seen to attend to the individual resident's social needs for recreation throughout the inspection. Staff interaction was observed to be predominantly task-oriented, centred around activities of daily living and lacked meaningful engagement. Residents were seen to spend long periods of time in their rooms, with limited stimulation other than music or television playing in the background.

5. Residents daily social activities of the residents will be reviewed by the PIC. Residents who do not prefer to attend general activities and wish to stay in the room, specific activities will be provided on them.

Institutionalized practices were observed such as the communal use of some under-garments. There was no labelling system in operation to identify which resident they belonged to, and this collective use of personal garments did not ensure residents' dignity was preserved.

6. Undergarment (nets) was removed and in future only disposable nets will be used.

The absence of call bells from two communal spaces in the centre meant that residents did not have the opportunity to seek help if required or exercise choice at all times.

7. Call bells replaced in the communal areas. Call bell register audit will be completed regularly by the CNMs and maintenance team. This is to check, and monitor all call bells are present and operational.

Residents were being administered their medications during lunch, which did not support their right to enjoy their meals without being disturbed.

8. All residents' medication times, and administration were adjusted to prior and post-protected resident mealtimes. MAR sheets were reviewed and updated.

Person (s) Responsible: Registered Provider Representative

Timeframe: July 30, 2024

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	30/08/2024
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	30/08/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/08/2024
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and	Not Compliant	Orange	30/09/2024

	needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.			
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	30/09/2024
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	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 concerned.	Substantially Compliant	Yellow	30/08/2024
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	30/08/2024
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient	Not Compliant	Orange	30/09/2024

	resources to ensure the effective delivery of care in accordance with the statement of purpose.			
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	30/09/2024
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 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.	Not Compliant	Orange	30/08/2024
Regulation 24(2)(a)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of	Not Compliant	Orange	30/08/2024

	the services to be provided, whether under the Nursing Homes Support Scheme or otherwise, to the resident concerned.			
Regulation 24(2)(b)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of the fees, if any, to be charged for such services.	Not Compliant	Orange	30/08/2024
Regulation 24(2)(c)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of where appropriate, the arrangements for the application for or receipt of financial support under the Nursing Homes Support Scheme, including the arrangements for the payment or refund of monies.	Not Compliant	Orange	30/08/2024
Regulation 24(2)(d)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of	Not Compliant	Orange	30/08/2024

	any other service of which the resident may choose to avail but which is not included in the Nursing Homes Support Scheme or to which the resident is not entitled under any other health entitlement.			
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	30/07/2024
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	30/08/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/08/2024
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs,	Not Compliant	Orange	30/06/2024

	the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.			
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.	Not Compliant	Orange	30/07/2024
Regulation 34(2)(d)	The registered provider shall ensure that the complaints procedure provides for the nomination of a review officer to review, at the request of a complainant, the decision referred to at paragraph (c).	Not Compliant	Orange	30/07/2024
Regulation 34(2)(e)	The registered provider shall ensure that the complaints procedure provides that a review is conducted and concluded, as soon as possible and no later than 20 working days after	Not Compliant	Orange	30/07/2024

	the receipt of the request for review.			
Regulation 34(2)(f)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant of the outcome of the review.	Not Compliant	Orange	30/07/2024
Regulation 34(2)(g)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant when the complainant will receive a written response in accordance with paragraph (b) or (e), as appropriate, in the event that the timelines set out in those paragraphs cannot be complied with and the reason for any delay in complying with the applicable timeline.	Not Compliant	Orange	30/07/2024
Regulation 34(5)(b)	The registered provider may, where appropriate assist a person making or seeking to make a complaint, subject to his or her agreement, to identify another person or	Substantially Compliant	Yellow	30/07/2024

	independent advocacy service who could assist with the making of the complaint.			
Regulation 34(7)(a)	The registered provider shall ensure that (a) nominated complaints officers and review officers receive suitable training to deal with complaints in accordance with the designated centre's complaints procedures.	Not Compliant	Orange	30/07/2024
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).	Not Compliant	Orange	30/09/2024
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Not Compliant	Orange	30/09/2024
Regulation 5(4)	The person in charge shall	Not Compliant	Orange	30/09/2024

	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.			
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Not Compliant	Orange	30/09/2024
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Not Compliant	Orange	30/09/2024
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	30/09/2024
Regulation 8(2)	The measures referred to in paragraph (1) shall	Not Compliant	Orange	30/09/2024

	include staff training in relation to the detection and prevention of and responses to abuse.			
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	30/07/2024
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	30/07/2024
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant	Orange	30/07/2024
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Not Compliant	Orange	30/07/2024