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 June 2022
Centre ID:	OSV-0000072
Fieldwork ID:	MON-0036925

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 54 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 38 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:	38

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 23 June 2022	09:30hrs to 19:05hrs	Helena Budzicz	Lead
Thursday 23 June 2022	09:30hrs to 19:05hrs	Brid McGoldrick	Support

What residents told us and what inspectors observed

This inspection took place over one day. Inspectors met most of the residents during the inspection and spoke with six residents in more detail to see what life was like living there. The overall feedback from residents was that they were happy living in the centre, that it was a nice place to live, and they were well looked after. Many residents who the inspectors met were unable to fully verbalise their needs and wishes. Inspectors saw that these residents appeared to be content and relaxed in the company of staff when observed throughout the day. According to information from the centre's management, approximately 75% of residents living in the centre were living with a moderate to severe cognitive impairment. While many staff were seen to engage in positive interactions with residents, inspectors observed a number of instances where residents were supported in a task-orientated manner, and more could be done to ensure continual delivery of person-centred orientated care.

On arrival at the centre, inspectors were met by the provider representative. In the course of an opening meeting with the management team, inspectors discussed the previous inspection findings, the compliance plan submitted following the inspection in April 2022, progress on recruitment and on the outstanding actions required following the previous inspection. Inspectors invited the person in charge and the provider to accompany inspectors on a tour of the premises. At the time of inspection, there were 38 residents in the centre with 16 vacant beds.

During this walkaround, inspectors observed that the corridors were busy areas, with staff observed going in and out of residents' bedrooms attending to morning care. A number of residents were up and dressed, sitting in the sitting room watching television or listening to music. Inspectors observed that some residents enjoyed activities sessions in the main sitting room in the centre. Residents were observed laughing and partaking in bingo. However, there were very limited opportunities for social stimulation for residents who were not able to participate due to progressive dementia or mobility impairment. Inspectors also observed the small sitting room in St Margaret's care unit and saw that although this area was well supervised throughout the day, there were minimal opportunities for residents here to participate in activities.

Inspectors acknowledged that parts of the premises were being refurbished and attended to and saw that one room was being painted on the day of the inspection. In addition, the provider took appropriate steps to promote fire safety in the centre. Room 15 located in the lobby area, was vacant, and a wooden structure which was a smoking room had been removed. Inspectors were informed that staffing for household duties had been increased since the last inspection. However, some rooms and areas of the centre were found not clean and were in need of upgrading. Inspectors brought to the attention of the management team some areas concerning infection control, mainly the cleanliness of the general environment, residents' bedrooms and equipment, as detailed further under Regulation 27:

Infection control. Nevertheless, inspectors found that while there was a stated willingness to improve the standards of environmental hygiene, there was an apparent lack of knowledge and skills, and the provider had failed to resource and address appropriate improvements adequately.

Inspectors also observed that a number of call-bells were missing. The main call-bells were answered promptly on the day of inspection; however, one resident told inspectors that when calling for assistance during night hours, on more than one occasion, the staff moved the bell so he could not reach it. The matter was discussed with the management team, and a full investigation and safeguarding plan was requested.

Residents reported that they enjoyed meal time in the centre, and the inspectors saw that the food was of good quality. Inspectors saw that menus were displayed on residents' tables with a variety of condiments. The inspectors saw that residents who required help were provided with assistance in a sensitive and discreet manner.

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

Capacity and capability

Overall, the findings of this unannounced inspection were that the centre did not have adequate capacity, capability and leadership to support staff with appropriate knowledge to deliver the best evidence-based person-centred care and a high level of quality and safe services to the residents.

The centre had a recent history of poor compliance with the regulations identified over the course of two-days inspections on 12 April 2022. There had been ongoing engagement with inspectors of social services, which included immediate action plans and assurances in respect of the healthcare and advocacy services available for residents in the centre. The provider submitted a compliance plan following the inspection. This inspection was undertaken to assess whether the changes outlined in the compliance plan and the actions plans submitted to the Chief inspector as part of the assurances sought by the inspectors had been implemented and were effective in ensuring the safety and welfare of residents in the centre and in improving regulatory compliance.

Moyglare Nursing Home Ltd is a limited company comprised of two directors. One director is the person in charge, and the other director is the provider representative. Both directors are present in the centre on a full-time basis. The daily running of the centre was overseen by the person in charge with the support of the provider representative. However, as identified in the previous inspection, the support arrangements in place were not effective and strong enough to maintain sufficient clinical oversight of residents' nursing and medical needs, and it was

evident from the findings of this inspection that the person in charge required additional on-site support in establishing and maintaining systems to ensure effective and safe management and oversight of the centre. The provider informed inspectors that they were outsourcing an external consultation company to support them in achieving compliance with the regulations. However, this arrangement was not established at the time of the inspection.

The designated centre is registered for 54 beds and there were 38 residents present on the day of inspection. Inspectors reviewed the staffing levels on the day of the inspection and found that the number and skill-mix of staff on duty were appropriate to meet the needs of the residents. However, a review of the rosters showed that staffing levels were not sufficient to meet the needs of residents and the supervision of staff. Staff worked a vast amount of hours to cover the staff vacancies during staff leave as further under Regulation 15: Staffing.

Key-performance indicators in relation to accidents or incidents, rates of infection, nutritional status, use of restrictive practices, skin integrity and use of anti-psychotics were gathered monthly. In addition, audits on different areas of practice were being conducted by the person in charge. However, inspectors found areas requiring action that the governance and oversight systems had not identified. Improvements were required in the frequency of the audits, the analysis and implementation of improvement plans to ensure comprehensive action plans were developed and followed up to respond appropriately to audit findings.

Copies of the appropriate standards, regulations and national guidance for the sector were not available to staff.

Regulation 15: Staffing

Inspectors reviewed worked and planned rosters and identified that there was a reliance on staff to work additional hours when the staff went on different types of leaves. For example;

- Over a two-week period, one nurse had worked a total of 120 hours, 48 hours more than their contracted hours. There were four healthcare assistants who worked at least 96 hours and a maximum of 108 hours over a two-week period, which is 36 hours more than their contracted hours.
- There was an insufficient number of cleaning hours allocated to ensure that the centre was appropriately cleaned. While additional housekeeping staff had been rostered, the shift was not replaced when a staff member went on leave. The impact of this is discussed under Regulation 27: Infection control.
- The provider informed inspectors that the introduction of a Clinical nurse manager role to provide leadership and clinical oversight would take place when the nursing post is back-filled. Additionally, the vacant healthcare assistants positions remained unfilled.

Judgment: Not compliant

Regulation 16: Training and staff development

The staff did not demonstrate an appropriate knowledge relating to the care of residents with falls, cleaning procedures, restraint and medicines management. The most up-to-date nursing guidelines published in 2020, and a copy of the regulations were not accessible to staff.

Management staff did not demonstrate understanding of the Health Act and associated statutory instruments in discussions around personal space to be provided to residents.

Judgment: Not compliant

Regulation 21: Records

While there were records available on wounds and repositioning, the provider did not ensure that the following records were kept and used as per the centre's policy and were not available for review on the day of the inspection:

- Records of falls did not include treatment provided to residents, for example, if first aid treatment was delivered. If the resident experienced an unwitnessed fall, the inspectors observed gaps in the neurological observations recorded.
- The Restraint release form was not in use.
- The Fall prevention and environment form in the residents' wardrobes was not updated since 2015.
- The record of medication errors and omissions did not reflect the medication errors and omissions identified on the day of the inspection.
- The record on the adverse reaction post-COVID-19 vaccination was missing.

Judgment: Not compliant

Regulation 23: Governance and management

The leadership and management systems in place did not provide clinical oversight and knowledge, appropriate staff supervision and monitoring of the quality and safety services. This was evidenced by:

- The governance and management structures had not been strengthened

since the last inspection, and no additional clinical management personnel had been put in place to support the person in charge. This continued to have an impact on the oversight of a number of key-areas, as highlighted in the report.

- The centre's own quality assurance systems had not identified a number of risks and areas of non-compliance found by the inspectors during this inspection. Despite the significant findings from the inspection in April 2022 and information and assurances submitted by the provider in the compliance plan, inspectors saw no evidence that the quality and safety of the services were effectively monitored as no audits had been completed in order to identify and drive improvements in the centre. For example, an audit on Infection control and prevention practices in the centre was last time completed in February 2022, and the audit on Manual handling practices was completed in January 2022. Furthermore, poor oversight of risks identified, for example, poor fall management, had a negative impact on residents.
- The system of monitoring and reviewing medication management was ineffective. The medication errors identified on the day of the inspection had not been identified by the management team during the medication management audit. The centre had completed a recent medication audit which identified high levels of compliance with medication management, in direct contrast to what inspectors observed on the day.
- The provider had submitted a compliance plan on the previous inspection findings stating that the quality and safety report was updated to reflect residents' and families' views. Inspectors observed that the quality and safety report for 2021 was updated; however, there was no evidence that feedback from residents and families was sought. The person in charge stated that they were going to complete the residents' care audit; nevertheless, none of the questionnaires was completed as seen on the day of the inspection.
- Inspectors found that the provider had failed to take action within the compliance plan of the last inspection. Repeat findings were seen in regulations 15: Staffing, Regulation 16: Training and staff development, Regulation 23: Governance and Management, Regulation: 5 Individual Assessment and Care Plan, Regulation 9: Residents' Rights, and Regulation 7: Managing behaviour that is challenging.

Judgment: Not compliant

Regulation 30: Volunteers

The inspectors reviewed a sample of files for people involved on a voluntary basis with the centre and found that some files did not have their roles and responsibilities set out in writing, and there were no adequate arrangements for their support and supervision clearly outlined.

Judgment: Not compliant

Regulation 4: Written policies and procedures

Inspectors found that the medication management policy was not updated in accordance with the best-evidenced nursing practise to support staff in the implementation of NMBI Guidance for Registered Nurses and Midwives on medicine Administration (2020).

Judgment: Substantially compliant

Quality and safety

The findings of this inspection showed that staff strived to provide a good quality of life to the residents living in the designated centre. However, despite the good nature and respectful approach of staff, inspectors were not assured that the centre was operating with a person-centred approach to care. Clinical oversight of the medical and nursing care of the residents continued to be insufficient to ensure the safety and well-being of residents were maintained and helped the residents to maximise their independence and autonomy.

Inspectors reviewed a number of residents' medical and nursing records. Documentation around residents' wound care had significantly improved, and there was evidence that wounds were regularly assessed, appropriate referrals to wound care specialists were made, and recommendations were followed. At the same time, inspectors reviewed a sample of residents' care files, accidents/incident documentation and fall policy in respect of falls for the months of April to the date of inspection. A total of nine falls had occurred (two falls in April, five in May and two in June). All falls were unwitnessed (no staff in attendance), and two residents sustained severe injuries. Inspectors concluded that, where residents are assessed at risk of falling, appropriate supervision was not provided and that assessment and care following falls was not recorded in line with evidenced-best nursing practice and centre's policy. Staff spoken with confirmed that they did not assess for possible signs of contributing factors for falls such as infection or low blood sugar. Furthermore, falls and mobility-associated care plans were not updated to reflect residents' changing needs.

Medicine management practices observed and as described to the inspectors were not found to be safe, and further actions were required to minimise the risk of medication-related errors occurring.

Although residents' self-reported experience of living in the centre was mostly positive, the inspectors found that a number of improvements were needed to support residents' rights to privacy and dignity as outlined under Regulation 9:

Residents' rights.

Regulation 11: Visits

Visiting was facilitated in line with current Health Protection Surveillance Centre (HPSC) guidance, COVID-19 Guidance on visits to Long Term Residential Care Facilities. The inspectors observed that visitors visited their loved ones in their bedrooms.

Judgment: Compliant

Regulation 17: Premises

The provider had not ensured that the premises were appropriate to the needs of the residents. The provider submitted a compliance plan following the inspection in April 2022 on how to comply with Regulation 17: Premises. However, inspectors observed minimal improvements and found repetitive findings. For example:

- Ramped floor areas were not highlighted as a safety measure to ensure care on approach. There was a sign on the doors; however, this did not alert residents living with dementia or visual impairment that the floor was uneven.
- Mobility equipment such as hoists was inappropriately stored in corridors around the centre when not in use.
- Emergency call facilities or chords were not accessible from each resident's bed and in every room used by residents. Inspectors observed that the call bells were discontinued from the walls or were missing.

The communal bathroom in the St Margaret's was out-of-order and was used as a staff changing room and a storage room. An urgent compliance plan was issued to the provider during the inspection to address this issue immediately in order to come into compliance with Regulation 17: Premises (S.I. No. 415/2013 Health Act 2007) Care and Welfare of Residents in Designated Centres for Older People Regulations 2013.

Judgment: Not compliant

Regulation 27: Infection control

A number of issues were identified during the course of the inspection which are not consistent with effective infection prevention and control measures and are detailed

below:

- Many areas of the centre were not cleaned to an acceptable standard, and inspectors observed multiple staining on walls, doors, radiators and furniture, curtains and armchairs. A number of items of equipment were visibly unclean, including residents' commodes, hoists and shower chairs.
- Procedures for terminal cleaning of vacant rooms were ineffective: a number of vacant rooms which had been signed off as terminally cleaned were found to have stained doors, wardrobes, walls, sinks and curtains. Different items were found in the wardrobes of these unoccupied rooms, including open pads. A box with equipment was stored on the floor. These unoccupied bedrooms were not cleaned to a high standard to be offered to new residents on their admission.
- Multiple hand-hygiene dispensers were visibly unclean.
- A number of over-bed tables were chipped and rusty and therefore could not be effectively cleaned.
- Specimens with bodily fluids were stored in the fridge assigned for the drug store.
- Sterile dressings were left open on the shelves. This posed a risk of the spread of healthcare-associated infection to residents in the centre due to cross-contamination of pathogenic microbes.
- Inspectors observed staff not adhering to correct infection control practices; for example, staff were using gloves and aprons on the corridors or staff who provided direct care to residents were seen walking into the kitchen and preparing residents' food without wearing appropriate attire to prevent cross-contamination or wearing personal protective equipment from the kitchen and walking around the centre.
- Routine environmental sampling for Legionella was not undertaken to monitor the effectiveness of the controls that were in place.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Inspectors were not assured that the medication management systems in place were safe and effectively monitored and that the 10 rights of medication administration were consistently implemented. For example:

- The centre has a policy on transcribing and routinely transcribes medications from residents' prescriptions onto a Kardex (a medicines management system, file indexing system), which is then used as the record of what medication to administer to residents. Inspectors found a number of transcribed Kardexes where there was no signature of the second nurse who reviewed the Kardex, or the date of transcription was five months old, which was not in line with the centre's policy.
- Several pain-reliever medications transcribed into the Kardex were observed

to be over the maximum recommended daily dosage; this was not a safe practice and had not been identified by the nursing staff.
- The maximum dose over 24-hours on PRN medication (When required) transcription was missing in all Kardexes reviewed.

Transcribing medications is a high-risk practice and can contribute to errors.

- The inspectors saw that some residents required their medications in an altered format, such as crushed medications. However, inspectors noted that these medications had not always been administered as prescribed in alternative forms of medications, such as liquids.
- Inspectors observed that while care plans for seizure were in place, the timing of administration of respective doses and circumstances and intervals of administration was missing.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

While the wound management assessments and care plans were in place and were updated and monitored on a regular basis, inspectors reviewed a sample of mobility care plans where residents experienced a fracture following a fall in the centre. The care plans were not updated with measures to prevent further falls in the centre and to ensure a safe recovery. In addition, a plan on how to support residents to restore back their mobility and independence to the level prior to the fall was missing.

Pain relief care plans for residents who experienced acute or chronic pain were not in place or were not updated in response to the changing needs of residents.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

While the restraint register was updated on the use of bedrails, lap-belts and chair-table attachment in the centre, the use of environmental-restrictive practice and chemical-restrictive practice in the centre was not reflected and regularly monitored in the centre's restraint register. Inspectors saw evidence that there was a use of antipsychotics in the centre's KPIs (key performance indicators) data collections and residents' administration records.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The findings of this inspection in relation to residents' rights were similar to the last inspection findings on April '22. Some routines and care practices required review to ensure that the residents' privacy and dignity were maintained and that the residents were able to exercise choice. By way of example:

While there were lockable cabinets in residents' bedrooms, the keys were not in the bedrooms. The person in charge informed inspectors that the keys were removed as the residents were not using them.

- There were three communal rooms; however, one of these rooms was now a reflection room and oratory. The room was also used for training, and a sheet covered a picture. The oratory continues to be a staff and storage room. However, the altar and other religious features were still placed there. As a result, residents were not supported to exercise their religious rights.
- Inspectors observed instances of poor practices by staff where staff did not pay attention to residents' dignity in communal areas. For example, staff continue to transfer residents in wheelchairs without foot-pedal support. Residents' clothes were wet from bodily fluids, or the feeding tube was exposed on the resident's clothes while transferring in the wheelchair.
- Residents in the care unit continued to have restricted access to the enclosed courtyard garden as the door in the sitting room was closed with a key-pad. As a result, if the resident wished to access the garden from the care unit, staff had to open the door for them. As some residents did not have the ability to ask the staff for support, it meant that they could not freely access the garden when they wished.
- A number of the twin bedrooms did not provide each of the residents with an adequate amount of private space. The personal space of the resident who had their bed positioned near the wardrobes and sink had their privacy limited as the other resident would have to stand near their bed if they wanted to use the sink or access their personal possessions in the wardrobe. Inspectors were not assured if their private space filled the criteria of 7.4 m2 for a resident as per requirement in the regulation.
- Inspectors were not assured if the privacy and dignity were supported for residents under the age of 65 years old residing in the centre. Despite 16 vacancies on the day of the inspection, two younger residents occupied a twin-bedroom in the care unit. There was no evidence on residents' files that these residents or their representatives were consulted and offered other single-room-occupancy accommodation which could better suit their needs and support their privacy. Furthermore, inspectors were not assured if they received an appropriate level of engagement and social stimulation appropriate to their age and level of interest.

The opportunities available to residents to participate in activities were limited, as observed on the day of inspection. Inspectors observed that residents spent long periods of time in the sitting room with no supervision from staff or any form of stimulation. Inspectors observed residents in a distressed state after lunchtime

taking clothes off. Inspectors observed that the healthcare assistant team prioritised the delivery of personal care and meeting residents' physical and basic needs in residents' bedrooms. The activities coordinator played bingo with seven residents in the main sitting room; the rest were either watching TV or residents who could not participate or were left in their wheelchairs without any interactive stimuli. There were no activities provided in the care day room on the day of the inspection. Furthermore, there was also limited evidence of one-to-one activities for those who wished to remain in their bedroom throughout the day.

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 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 30: Volunteers	Not compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Moyglare Nursing Home OSV-0000072

Inspection ID: MON-0036925

Date of inspection: 23/06/2022

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:
Specific
Inspectors reviewed worked and planned rosters and identified that there was a reliance on staff to work additional hours when the staff went on different types of leaves.

Measurable
• Review the staff duty rosters and the required hours.
• To put a mechanism to review and monitor staff vacancies and how to cover.
• Additional Staff Recruitment
• Recruitment of senior management role to provide strong leadership and clinical oversight

Achievable
The Registered Provider has reviewed the Organisation of Working Time Act 1997 to ensure that Moygleare Nursing Home is compliant pertaining to the regulation governing weekly working hours set specific 15 (1).
The Registered Provider have currently put in place active recruitment campaign for additional staff members (both clinical and non-clinical) and successfully recruited a new General Manager and Person In charge to strengthen the governance structure and to provide leadership and clinical oversight in MNH. A new governance structure (algorithm) with defined roles and responsibilities will be in place and will be reflective in the Statement of Purpose.
Further, the Registered Provider of MNH reviewed and calculated the Residents dependency level report using the method of widely used in Ireland and UK, this is to determine the total number of nursing/care hours vs actual deployment of clinical staff (SN, HCA, and Activity Staffs) with direct care contact to residents to ensure sufficient number of staff are appropriately put in place.
Staff duty rosters will be reviewed regularly and approved by senior management prior to issuance in service units. This is to ensure that correct number of staff are appropriately in each department are put in place. On a daily basis, review and identify the following;
• any foreseen staff vacancies due to sick, emergency/planned annual leaves. Always

take into consideration the number of the residents in the units.
• A separate duty roster for each department will be generated to ensure vacancies will be highlighted and covered due to annual leaves, sick leaves and vacancies.
• Appropriate number of cleaning hours and staff are allocated in cleaning staff duty roster.
• Staff working hours will be closely monitored by the senior management team to ensure compliance under existing regulations
New governance team will be put in place by the Registered Provider. Post for General Manager and PIC (successfully recruited) with huge clinical background in acute and staff training development. This is to ensure the provision of strong clinical leadership and oversight in MNH. Additional, clinical and non- clinical staff were also recruited.

Relevant
Each staff member has a key role to play in delivering person centred, effective and safe care to residents. The centre should be managed by people who have been appropriately trained to manage the facilities and services to the residents.

Time Bound
September 30, 2022

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Specific
The staff did not demonstrate an appropriate knowledge relating to the care of residents with falls, cleaning procedures, restraint and medicines management. The most up-to-date nursing guidelines published in 2020, and a copy of the regulations were not accessible to staff.
Management staff did not demonstrate understanding of the Health Act and associated statutory instruments in discussions around personal space to be provided to residents.

Measurable
Review of MNH Staff Training and Development for Mandatory and Support. Training needs analysis is completed periodically to ensure that staff have the required skills and knowledge.
Identify and prioritized specific trainings for staff, training portfolios/materials and other resources required.
Review of medication Management Policy.

Achievable
The Registered Provider has recruited a General Manager and Person in charge with nursing qualifications, with previous managerial positions in acute and long-term care

and strong background in staff training and development.
The Person in charge and General Manager will facilitate regular in-service training under support trainings matrix of MNH in the areas of;
• Falls Management
• Health Act
• Infection Control and Prevention
• Cleaning and Decontamination
• Use of Enablers to avoid mechanical Restraint.
• Reduction of Psychotropic Medications Usage
• Medication Management
• Incident Reporting
External counterparts/training services will be supporting the training requirements of MNH.
Mandatory Trainings for staff will also be prioritized.
Monitoring of compliance will be made in 2nd level oversight mechanism.
A separate/ specific work structure and deliverables are assigned to ensure compliance and progress in this area.

Relevant
The centre should ensure always that staff have the required competencies to manage and deliver person-centred, effective and safe services to all residents.

Time Bound
September 30, 2022

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Specific
While there were records available on wounds and repositioning, the provider did not ensure that the following records were kept and used as per the centre's policy and were not available for review on the day of the inspection:

Measurable Review of incident reports.
Develop a plan to adapt alternatives for least restrictive practices for residents.
Develop a plan for effective auditing system with oversight mechanism to ensure compliances of standard of resident's care.
Review the falls prevention program of the centre and records pertaining to Covid 19 vaccination of Residents

Achievable
All incident reports generated weekly/monthly will be reviewed. To include the any gaps in the immediate treatment/interventions provided to residents. A summary of monthly resident incident reports will be generated. Quarterly Risk Management analysis will be

generated.
All incident reports generated weekly/monthly will be reviewed to identify gaps in the recordings. To include the immediate treatment/interventions provided to residents. A summary of monthly resident incident reports will be generated. Quarterly Risk Management analysis will be generated.
A new Incident Reports audit tool will be implemented.
Enabler system will be implemented for the residents in MNH. New Risk Assessment form and application/release templates will be adapted. New individual resident care plan in relation to the use Resident Enablers will be developed. Enablers will be incorporated in MNH Clinical Risk Register.
A new environmental risk assessment form to prevent and or reduce falls will be adapted for local used. All fall nursing assessments and care plans will be reviewed and updated to include evaluation and care plan discussion to residents and or families. Falls in service training will be facilitated to staff members.
Medication Audit will be implemented regularly in the clinical unit. All previous records of Medication Errors will be reviewed. Root cause analysis will be incorporated. In-service training will be provided/scheduled including refresher course for medication and management. Pharmacy Audit will be scheduled immediately.
All records of resident Covid 19 vaccination records records will be secured appropriately. A new archiving system will be implemented.
Monitoring of compliance will be made in 2nd level oversight mechanism. A separate/ specific work structure and deliverables are assigned to ensure compliance in this area.

Relevant
Arrangements to ensure appropriate record keeping and file management systems are in place to deliver a person centred safe and effective service. Record keeping is an integral part of care, and the purpose of record keeping is to ensure the continuity of care and to safeguard residents.
Audit tools and oversight mechanism to ensure compliances of standards to better safeguard the welfare of the residents.

Time Bound
September 30, 2022

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Specific
The leadership and management systems in place did not provide clinical oversight and knowledge, appropriate staff supervision and monitoring of the quality and safety services.

Measurable
Review of Governance Structures, Roles and Responsibilities.
Review of MNH Statement of Purpose.
Develop an audit system with strong oversight mechanism to ensure compliance.
Develop a resident center focus survey questionnaires.

Achievable
Registered Provider will put in place a new Governance and Management team. GM (new role) and PIC (new).
The new governance structure and reporting system with defined responsibilities will be reflective in the MNH Statement of Purpose to submitted to HIQA. The management structure has defined lines of authority and accountability.
New audit tools will be incorporated in the areas of Infection Control, Environmental, Medication Management, Falls, Pressure sores, Enablers, Psychotropic medications, care plans, assessments and paper based clinical documents. Specific roles and audits were assigned to PIC, GM and SSN with oversight mechanism in place.
Medication Audit will be implemented regularly in the clinical unit. Pharmacy Audit will be immediately scheduled.
All previous records of Medication Errors will be reviewed. Root cause analysis will be incorporated. In addition:
• In -service training will be provided including refresher course for medication and management.
• Monitoring of compliance will be made in 2nd level oversight mechanism.
• A separate/ specific work structure and deliverables are assigned to ensure compliance in this area.
Registered Provider and PIC will facilitate the Resident Annual Survey immediately. Questionnaires will be distributed to residents and families.
Review of the current database of Residents' activity profiles and monthly calendar of events. The activity plan of residents requires to be amended. Sensory-based activities (appropriate social activities) should be incorporated for residents with a high degree of mobility and with moderate to advance stages of dementia. The sensory-based activity plan will be designed by the activity staff members 7 days a week. (Currently full-time activity staff Mon-Fri/Part-time activity staff Sat-Sun in place. Recordings of social activities should be made in Residents' Activity progress notes. Accountable person(s) was assigned
Resident call bell register will be adapted in resident rooms, toilets, bathrooms and communal areas. Daily checking/signing sheets 2x per day (day and night will be facilitated). New checking/signing sheets will be developed. Monitoring of compliance will be made in 2nd level oversight mechanism. Procurement of new resident call bells wre completed.

Relevant
Continuous assessment and audits are key to a robust quality improvement strategy in the centre.
The centre should be managed by people who have the required skills and experience the necessary services to safeguard the well-being of the residents.

Time Bound

September 30, 2022

Regulation 30: Volunteers	Not Compliant

Outline how you are going to come into compliance with Regulation 30: Volunteers:
Specific
The inspectors reviewed a sample of files for people involved on a voluntary basis with the centre and found that some files did not have their roles and responsibilities set out in writing, and there were no adequate arrangements for their support and supervision clearly outlined.

Measurable
Review of centre policies and procedure specific to Volunteers

Achievable
Registered Provider and the new management team will develop policy and procedures specific to volunteers which will clearly outline their roles and responsibilities, arrangements, support, and provision.
• Mandatory requirements such as Garda Vetting, CV's and reference letters.
• Roles and responsibilities
• Time keeping, attendance and reporting structure.

Relevant
Residents living in the centre should be considered part of the wider local community and important resource. Resident engagement and mood appeared to improve during volunteer-led activities.

Time Bound
September 30, 2022

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
Specific
Inspectors found that the medication management policy was not updated in accordance with the best-evidenced nursing practise to support staff in the implementation of NMBI Guidance for Registered Nurses and Midwives on medicine Administration (2020).

Measurable Review and Update of the Medication Management Policy.

Achievable
The Registered Provider and the new management team will review and update the Medication Management Policy of MNH incorporating the NMBI Guidance for Registered Nurses and Midwives on medicine Administration (2020).
NMBI Guidelines will be incorporated in Medication Management Training Course.

Relevant
Relevant PPPGs are in place to support and guide the nurse on Medication Administration. This is to better safeguard the well being of the residents in the centre.

Time Bound
September 30, 2022

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Specific
The provider had not ensured that the premises were appropriate to the needs of the residents. The provider submitted a compliance plan following the inspection in April 2022 on how to comply with Regulation 17: Premises. However, inspectors observed minimal improvements and found repetitive findings.

Measurable
Review appropriate signage system, appropriate storage area for hoists and equipment when not in use, and call bell system in the centre.
Adapt a system to monitor and ensure compliance in this area.

Achievable
Registered Provider to change the signage in ramped floor areas with dementia friendly symbol, contrast and colours appropriate for residents with visual impairment to ensure safety.
Hoists will be stored in a safe manner when not in used. Designated area in place. This will be included in the daily environmental audit. A new audit tool for will be incorporated.
Emergency call/chords will be put in place in each resident bed and rooms. Registered Provider will procure new emergency resident call bells. This will be included in the daily environmental audit. A new audit tool for will be incorporated.

Relevant
The centre should replicate the residents' previous home life, preserve their dignity, residents live in a comfortable, clean and safe environment.

Time Bound
September 30, 2022

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Specific
A number of issues were identified during the course of the inspection which are not consistent with effective infection prevention and control measures

Measurable
Review and identify the required audit tools to ensure compliance of standards in this area.
Review and identify the required training to be implemented to improve staff knowledge and understanding.
Regular schedules should be maintained for Water Sampling (Legionella)

Achievable
Daily environmental audit will be implemented. To include equipment, furniture's, curtains, armchairs and walls.
Daily environmental audit will be implemented. To include hand hygiene dispenser.
Specific fridge to be used for specimens with bodily fluid.
All dressing materials will be kept securely store in the clinical rooms. Daily environmental audit will be implemented to include dressing materials storage. This will be covered by daily environmental audit.
Monitoring of compliance will be made in 2nd level oversight mechanism.
Support training matrix for staff in the areas of (will be implemented)
• Infection control
• Equipment cleaning and decontamination
• Hand hygiene
• Appropriate disposal of clinical and non- clinical waste
• Use PPE's
This will be included in the daily environmental audit
Routine environmental sampling for Legionella will be facilitated immediately and regular schedule will be put in place. External service provider will be contacted.
A separate/ specific work structure and deliverables are assigned to ensure compliance in this area

Relevant
Infection Prevention and Control is paramount in the centre, it protects both the residents and healthcare worker from infectious disease.

Time Bound

September 30, 2022	
Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

Specific

Inspectors were not assured that the medication management systems in place were safe and effectively monitored and that the 10 rights of medication administration were consistently implemented.

Measurable

Review the Resident Medications Usage in the centre.
Identify appropriate tool to ensure compliance.
Identify the required training for staff to improve competencies and ensure standards.

Achievable

Medication Management refresher training for staff to be implemented. Practical assessment for the administration of medicines will be carried out
Residents Medication Usage Review will be scheduled immediately. Use of PRN Medications will be reviewed. MNH will put a formal process in place to ensure that the medications usage of the residents are regularly reviewed on a quarterly basis. GP's, nurses and pharmacist will be involved in the process of medication usage review for;

- Safe and rational prescribing
- Appropriate prescribing
- Minimizing side effects
- Minimizing drug interactions
- Minimizing drug errors
- Ensuring appropriate monitoring
- Shared decision making so the residents understand why they are taking certain medications.
- Cost effectiveness
- Improving residents' quality of life

Medication Management Policy to be updated incorporating the 202o NMBI guidelines.
New Pain Management Policy to be develop.
1st line and 2nd Line indicated in Resident Drug Kardex for prn Analgesia, Psychotropic, Laxative, and Anti-seizure medications. Maximum doses will be clearly indicated.
Alternative format for administering will be clearly indicated.
New template added to monitor the effect of PRN' medication to be attached in each Resident Drug Kardex and MAR Sheets.
Monitoring of compliance will be made in 2nd level oversight mechanism. A separate/ specific work structure and deliverables are assigned to ensure compliance in this area

Relevant
Safe medication prescribing and administration is important in safeguarding the well-being of residents in the centre.

Time Bound
September 30, 2022

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:
Specific
While the wound management assessments and care plans were in place and were updated and monitored on a regular basis, inspectors reviewed a sample of mobility care plans where residents experienced a fracture following a fall in the centre. The care plans were not updated with measures to prevent further falls in the centre and to ensure a safe recovery. In addition, a plan on how to support residents to restore back their mobility and independence to the level prior to the fall was missing.
Pain relief care plans for residents who experienced acute or chronic pain were not in place or were not updated in response to the changing needs of residents.

Measurable
Review of all resident's care plan is required

Achievable
The clinical team will review all residents care plans
Incorporate pain assessment for residents and corresponding care plans
To include evaluation, MDT approach and supportive plans in response to the changing needs of the residents.
Care Plan Audit tool will be implemented.
Monitoring of compliance will be made in 2nd level oversight mechanism. A separate/ specific work structure and deliverables are assigned to ensure compliance in this area

Relevant
Each resident has a care plan, based on an ongoing comprehensive assessment of their needs which is implemented, evaluated and reviewed, reflects their changing needs and outlines the supports required to maximise their quality of life in accordance with their wishes.

Time Bound
September 30, 2022

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
Specific
While the restraint register was updated on the use of bedrails, lap-belts and chair-table attachment in the centre, the use of environmental-restrictive practice and chemical-restrictive practice in the centre was not reflected and regularly monitored in the centre's restraint register. Inspectors saw evidence that there was a use of antipsychotics in the centre's KPIs (key performance indicators) data collections and residents' administration records.

Measurable
RP and PIC will adapt alternatives of implementing less restrictive practices.
Resident Clinical Risk Register for restraints will be reviewed.

Achievable
• New Enabler system in place to reduce the use of Psychotropic will be introduce
• New Psychotropic Medication Reduction system will be introduced
• Audit tool specific to Enablers and clinical documentations
• Audit tool specific to Residents PRN Psychotropic and documentations
• New Staff Training will be implemented in relation to Resident Enablers and PRN Psychotropic Medications
• Monitoring of compliance will be made in 2nd level oversight mechanism. A separate/ specific work structure and deliverables are assigned to ensure compliance in this area.

Relevant
Moyglare Nursing Home should manage the needs of all residents in an individualised manner. Residents with challenging behaviour, including behaviour which is a high risk to the individual themselves is managed and responded to effectively in an environment which promotes well-being and has the least restrictions.

Time Bound
September 30, 2022

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Specific

The findings of this inspection in relation to residents' rights were similar to the last inspection findings on April '22. Some routines and care practices required review to ensure that the residents' privacy and dignity were maintained and that the residents were able to exercise choice.

Measurable
Review Residents environmental premises, resident social activities and identify support plans to address staff's appropriate communications to residents.

Achievable
A designated area to facilitate residents exercise of their religious rights are now in place. This area will be kept clutter free and maintenance will be included in the daily Environmental Audit Tool.
A new switch system will be put in place in the enclose courtyard garden that will be accessible to residents in wheelchair.
A plan to move residents to be transferred to another rooms. Additionally, a refurbishment plan to be made by Registered Provider in relation to wardrobes access of resident
Refresher Training will be facilitated to staff in relation to Safeguarding the Vulnerable Adults and Communication.
Staff Observational Tool (new) will be facilitated to ensure appropriate communications of staff to residents.
Specific to 2 younger residents, the clinical team will review their support for additional services required.
Resident social activity profile, timetable, calendar of events will be evaluated. Specific plan to incorporate
Monitoring of compliance will be made in 2nd level oversight mechanism. A separate/ specific work structure and deliverables are assigned to ensure compliance in this area

Relevant
The core principle of care service delivery in the facility is one that protects and promotes the core human rights principles of fairness, respect, equality, dignity and autonomy.

Time Bound
September 30, 2022

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	30/09/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	30/09/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/09/2022
Regulation 16(1)(c)	The person in charge shall ensure that staff are informed of the Act and any regulations made under it.	Not Compliant	Orange	30/09/2022

Regulation 16(2)(a)	The person in charge shall ensure that copies of the Act and any regulations made under it are available to staff.	Not Compliant	Orange	30/09/2022
Regulation 16(2)(b)	The person in charge shall ensure that copies of any relevant standards set and published by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act are available to staff.	Not Compliant	Orange	30/09/2022
Regulation 16(2)(c)	The person in charge shall ensure that copies of relevant guidance published from time to time by Government or statutory agencies in relation to designated centres for older people are available to staff.	Not Compliant	Orange	30/09/2022
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Not Compliant	Orange	30/09/2022
Regulation 17(2)	The registered	Not Compliant	Orange	30/09/2022

	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.			
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	30/09/2022
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	30/09/2022
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	30/09/2022
Regulation 23(c)	The registered provider shall	Not Compliant	Orange	30/09/2022

	ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 23(e)	The registered provider shall ensure that the review referred to in subparagraph (d) is prepared in consultation with residents and their families.	Not Compliant	Orange	30/09/2022
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.	Substantially Compliant	Yellow	30/09/2022
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist	Not Compliant	Orange	30/09/2022

	regarding the appropriate use of the product.			
Regulation 30(a)	The person in charge shall ensure that people involved on a voluntary basis with the designated centre have their roles and responsibilities set out in writing.	Not Compliant	Orange	30/09/2022
Regulation 30(b)	The person in charge shall ensure that people involved on a voluntary basis with the designated centre receive supervision and support.	Not Compliant	Orange	30/09/2022
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	30/09/2022
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	30/09/2022
Regulation 5(1)	The registered provider shall, in so far as is	Not Compliant	Orange	30/09/2022

	reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).			
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	30/09/2022
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	30/09/2022
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	30/09/2022
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure	Not Compliant	Orange	30/09/2022

	that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.			
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	30/09/2022
Regulation 9(3)(e)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise their civil, political and religious rights.	Not Compliant	Orange	30/09/2022