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:	Moorehall Lodge Drogheda
Name of provider:	Moorehall Healthcare (Drogheda) Limited
Address of centre:	Dublin Road, Drogheda, Meath
Type of inspection:	Unannounced
Date of inspection:	15 July 2021
Centre ID:	OSV-0000737
Fieldwork ID:	MON-0033451

About the designated centre

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

The designated centre provides twenty-four hour support and nursing care to 121 male and female older persons, requiring both long-term (continuing and dementia care) and short-term (assessment, rehabilitation convalescence and respite) care. The philosophy of care adopted is the "Butterfly Model" which emphasises creating an environment and culture which focuses on quality of life, breaking down institutional barriers and task driven care, while promoting the principle that feelings matter most therefore the emphasis on relationships forming the core approach. The 'household model' has been developed to deliver care and services in accordance with the philosophy. The designated centre is a purpose-built three storey building situated on the outskirts of a town. It is divided into households; Rosnaree and Newgrange households, located on the ground floor, Millmount and Mellifont households situated on the first floor and Oldbridge and Beaulieu households on the second floor. Each household has its own front door, kitchen, open plan sitting and dining room.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	120

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 15 July 2021	07:30hrs to 18:00hrs	Nuala Rafferty	Lead
Friday 16 July 2021	08:00hrs to 17:00hrs	Nuala Rafferty	Lead
Thursday 15 July 2021	07:30hrs to 18:00hrs	Naomi Lyng	Support

What residents told us and what inspectors observed

Inspectors spoke with approximately 16 residents and six relatives over the course of the two day unannounced inspection. In general residents said they were satisfied with their care, that they felt safe and were supported by staff. The provider had made a number of changes in response to the findings of the previous inspection to improve the delivery and management of care and services. However significant focus and efforts were now required to improve the oversight and governance of the centre so that a high quality, safe and appropriate service is delivered for the residents going forward.

The inspectors spent time chatting with residents in the communal areas and around the grounds of the centre to hear what life was like living in the centre. Inspectors also chatted with visitors and spent time reviewing records of communications, meetings and other feedback forums available to residents, their families and advocates. Inspectors also spent time observing the interactions between residents and staff.

Residents and relatives feedback was largely positive on the care received and the commitment of staff to look after their needs. However there were mixed reports about the general experience of life in the centre.

Those residents who were more dependent and who could not talk with the inspectors, were observed to be comfortable and relaxed. Staff interactions with residents were warm and empathetic and many residents told inspectors they felt comfortable with the staff, who they said, worked hard and engaged with them in a respectful and polite manner.

Inspectors were told that a range of individual and group activities were held each day in every household by allocated staff members, however this was not confirmed by inspectors' observations on the day. An activity programme detailing the planned activities was available, but not displayed or delivered in every household during the two days of inspection. In addition, inspectors found that there were inconsistencies in the involvement of residents in the development of the activity programmes.

The inspectors observed that staff were rushing from one task to another and did not have time to chat with the residents. Several visitors told inspectors that they were happy with the care their relatives received in the centre, but also stated that their loved ones complained of being bored on a regular basis, or that they spent longer periods of time in their bedroom because there was nothing to do. Although staff were willing to facilitate residents wishes to go outside, in the absence of a safe enclosed garden, outdoor activities were supervised. Residents did have access to balconies where they could sit outside but said to the inspectors that this did not provide the same experience as a proper garden. One resident told their family that they were prevented from going outside for a walk alone by staff which left them

‘feeling like a child or something’.

Inspectors spoke to another resident who was sitting in a specialised chair in their bedroom, watching television. They said there were "good and bad experiences living here", adding ‘staff are great and really kind but you often have to wait for them to help you’. The resident felt it was especially busy at night and staff can be rushed 'I think people often don't show up for work and there's no-one to replace them’.

Residents were very complimentary of staff in the centre. Comments included; 'the care has been unbelievable - I couldn't have wished for better.' One resident who was recently bereaved said that staff had 'brought my smile back'. Another told inspectors that their meal choices were respected and that alternatives were also offered if they changed their mind. Several residents said they greatly enjoyed living in the centre and had 'no complaints and sure I would just tell them if I did'.

In general, residents were complimentary of the food choice and quality offered in the centre, and were seen to enjoy their meals. One resident said that the food was very good and another said they had lots to eat. Staff were seen providing assistance to some residents during lunch in a patient, respectful and cheerful manner. However, one of the inspectors also observed a staff member assisting residents with their meal while standing over them and one resident, who was clearly uncomfortable, asked the staff not to stand in front of them.

One of the inspectors observed a group bingo class taking place in the dementia specific household. Residents were supported by staff to take part and were clearly engaged and excited. It was evident that staff did their best to make it a fun time with lots of cheering. One resident won a hat as a prize and was very delighted. A resident who was reading a newspaper in the corner was laughing along with the game and looked comfortable and content. Staff told the inspector that a volunteer sometimes brought a number of residents out on a rickshaw in the good weather which they found was "lots of fun".

A resident with responsive behaviour (how residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) was observed shouting. Staff were kind and respectful and provided appropriate distraction in line with the care plan.

The centre is a large three storey building, divided into six households. Each household had a large living area, a smaller quiet area and access to a balcony with seating and planted tubs and baskets for residents to enjoy. The interior design and layout helped to promote a good quality of life for residents. One resident told the inspectors that they loved to sit and watch the view of the nearby town from their window.

Furnishings fittings and décor, together with good use of colour, pictures, signage and artefacts contributed to a comfortable living space that evoked memories of cultural significance to the residents who live there. Inspectors observed that overall the building equipment and fixtures were well-maintained and were in a good state

of repair. Some improvements had been made since previous inspection, including the installation of a magnetic self-closing device on fire doors leading to a communal sitting room.

All residents' bedrooms were spacious and contained a full en-suite, including shower. Residents told inspectors that they were very happy with their living arrangements, saying the rooms were comfortable and spacious. Most rooms were personalised with possessions to residents' individual taste and, in general, were seen to be clean and tidy. However, inspectors also observed some unclean basins and commode inserts left on the floor in a number of en-suite bathrooms.

The centre grounds were spacious with large planted rockeries around the perimeter of the car park at the front entrance. The sides and rear of the grounds contained a large lawn area and there was a paved pathway wrapped around the entire building which inspectors observed was well- used by residents and their friends and families for walks. A number of benches were available to allow residents and visitors take a rest and have a chat. However, inspectors observed that there was no accessible enclosed garden available to enjoy. Inspectors were told by a number of residents and relatives that they would like a garden with trees and shrubs and nice walkways, perhaps even a picnic spot. Some residents also said they would like to be able to do some gardening such as planting pots or baskets.

Staff who spoke with the inspectors were knowledgeable about the residents they cared for. They were familiar with the residents' preferred daily routines, care needs and the activities that they enjoyed. Staff were observed to respond to residents needs and call bells promptly, while maintaining their privacy and dignity.

The following sections of the report will describe the findings of the inspection and detail the level of compliance under each regulation.

Capacity and capability

Overall, the inspection found that some management systems in place were not sufficiently consistent or effective to identify areas for improvement. Furthermore, insufficient resources and inadequate oversight to monitor and supervise the conduct and operation of services had resulted in potentially serious risks to the safety and welfare of residents.

The inspection also found recurrent non-compliances in relation to fire safety, staffing, training and development, infection prevention and control and the governance and management of the service.

In addition, information of concern, both solicited and unsolicited, was received by the Chief Inspector in respect of residents' admissions and transfers to the centre and was partially validated on this inspection. An absence of clear systems, poor implementation of existing systems, inadequate communication and documentation

of care interventions did not ensure the management and provision of a safe and high quality service for some residents. Together with inadequate oversight to monitor and supervise the conduct and operation of services, this resulted in serious risks to the safety and welfare of residents. Overall, there were a number of areas identified as requiring significant improvement, these will be discussed further under the relevant regulations.

Moorehall Lodge Healthcare Limited is the registered provider of Moorehall Lodge Drogheda. The senior management team included the provider representative, person-in-charge and a recently appointed Director of Operations who works across two centres. This team was supported by human resources staff and a resident relationship manager, who was a qualified nurse responsible for the management of prospective residents, and who also provided support and mentorship to newly appointed staff. Two care managers and a catering and household supervisor provided additional front-line support.

Since the last inspection, key changes to the corporate management structures had resulted in a period of transition in the governance arrangements. These included changes to the internal management structures, such as the appointment of a new person in charge and a director of operations post. Inspectors acknowledged the difficulties inherent in managing organisational change, and the limited time available to embed changes made since the last inspection. The efforts made by the senior management team to manage the risks found on the previous inspection in January 2021 were also acknowledged. In particular, the progress made to fill the large number of staffing vacancies during such a challenging period.

Inspectors found that all nurse vacancies had been filled, and there were only a small number of health care, housekeeping and homemaker posts remaining to be filled. Nevertheless, the inspectors found that unexpected staff absences were not regularly replaced, and that when this happened, staff were reallocated to different roles to mitigate for absences. This resulted in negative impacts on residents; for example where planned activities were not delivered and some residents' requests for assistance to spend time outdoors could not be met.

Despite active efforts to recruit for clinical supervisory roles, at the time of inspection these vacancies had not been filled, and this had an impact on the monitoring of practices for both direct and non-direct care and nursing staff.

Inspectors saw evidence of good efforts to improve governance and management within the centre following the last inspection in the centre. These included the establishment of regular clinical governance meetings. The recently appointed person in charge commenced a programme of observational audits on clinical practice during May and June 2021. Inspectors found some evidence of good leadership by the person in charge and efforts to promote a more person-centred and rights-based approach to care practices. Inspectors saw evidence that the audit findings, recommendations and feedback, were communicated to staff during 'learning circles' led by the person in charge and the care managers.

Evidence that staff had access to and attended mandatory training in safeguarding,

moving and handling, fire safety and infection prevention and control was seen. Inspectors also found that there were on-going training opportunities provided to staff linked to their role. An induction training programme had been devised since the last inspection and was delivered to recently recruited staff. It included elements of both on-line and on-site training. However, this induction process had not been available to staff who were in post within the previous six to eight month period and inspectors observed that some staff did not have the appropriate skills to fulfill their role in relation to effective decontamination processes and use of equipment.

While all the required policies and procedures were available to guide staff in the provision of care, the inspectors found that not all of them had been updated in line with best practice guidelines and some were not implemented in practice, in order to ensure residents received a safe and high quality care. This is further described under Regulation 4.

An annual review was completed in respect of the manner and standard of services delivered to residents throughout 2020. The report included feedback from residents. Complaints were well-managed.

Regulation 14: Persons in charge

The person in charge was a registered nurse working full-time in the centre who met the requirements of the regulations.

Judgment: Compliant

Regulation 15: Staffing

The number and skill mix of staff on the days of inspection were not sufficient to meet all of the assessed needs of the residents in accordance with regulation 5 as evidenced by findings on the day of inspection.

Unexpected staff absences in both direct and non-direct roles, including household, homemakers and health care assistants were not replaced. In some instances, health care assistants were moved to the role of homemaker despite not having any experience or training in the re-allocated role. The household supervisor replaced an absent member of the household team and as a result could not perform their supervisory duties. Inspectors also became aware that on one residential household, an unplanned absence resulted in the non-replacement of a health care assistant for a two week period, including the period of inspection.

Judgment: Not compliant

Regulation 16: Training and staff development

Vacant management posts and the non-replacement of staff negatively impacted on the level of support, supervision and monitoring of practice provided to all grades of staff. Examples include poor moving and handling practices observed by inspectors and where the household supervisor was not in a position to have full oversight of the implementation of cleaning schedules or the standard of cleaning practice by the household team.

Inspectors identified the need for improvements in skills and competencies for staff and supervisory managers in the following areas:

- Supervision and monitoring of practice.
- Enhanced supervision arrangements, including a full review of the induction processes were required to ensure staff had the required competencies, adhered to and implemented local policies in practice
- Leadership and management.
- Upskilling of household and care staff was required in the use of equipment, and processes and procedures, relevant to their roles.
- Moving and handling practices.

Judgment: Not compliant

Regulation 23: Governance and management

Governance and management systems were not sufficiently robust to ensure that safe and appropriate care and services were being delivered for the residents. In addition the provider had not addressed a number of non-compliances from the previous inspection in relation to fire safety, staffing, training and development, infection prevention and control and risk management. These are addressed under the relevant regulations.

The centre was not appropriately resourced to meet resident's assessed needs, on the day of inspection as described under Regulation 15

Inadequate oversight and poor management of risks together with system failures contributed to a lack of safe care being provided to some residents.

Judgment: Not compliant

Regulation 34: Complaints procedure

The centre had a complaints policy and procedure in place and a number of complaints were recorded. Complaints had been promptly investigated and closed off to the satisfaction of the complainant.

The complaints procedure met regulatory requirements, was displayed in a prominent location in the centre, and there were suggestion boxes available in each household.

Judgment: Compliant

Regulation 4: Written policies and procedures

Some of the relevant policies had been updated to include COVID-19 guidance in 2021, but they needed further revision to reflect the most recent guidance.

Inspectors were not assured that the following policies were being fully implemented in practice :

- Risk management Policy
- Infection prevention and control
- Admissions Policy
- Temporary absence, transfers and discharges
- The creation of, access to, retention of, maintenance of and destruction of records.

Judgment: Not compliant

Regulation 21: Records

This regulation was not fully reviewed on inspection. However, some records were stored in a cupboard with flammable items and not retained in a safe manner.

In addition there were gaps in the recording and documentation of care delivered to residents.

Judgment: Substantially compliant

Quality and safety

Residents were provided with a good standard of care and support that met their basic needs, but significant improvements were needed to ensure that residents were safeguarded by safe admission procedures and clear protocols on transfers and discharges to the designated centre. Sustainable improvements were needed to uphold residents' rights to autonomy and independence, and consideration of their preferences, diversity and choice on a daily basis. In addition, considerable improvements were also required in the areas of premises, care planning arrangements and infection prevention and control as detailed under their respective regulations.

The centre contained a good variety of communal and quiet sitting rooms and spaces where residents, alone or with family and friends could spend time. However, issues were identified with a lack of storage and lack of appropriate staff change facilities and these aspects of the premises required to be reviewed as there was evidence of a negative impact on both residents and staff.

A record was kept, in respect of each resident, on their health personal and social care needs. However, a comprehensive assessment of the care and support required to assist each resident with all of their activities of daily living and a care plan to deliver that care, was not in place for each resident's identified needs. In addition, it was found that the standard of needs assessments and care planning was inconsistent and that some care plans were not being fully implemented by staff.

Good procedures were in place to manage risks associated with falls. These included links with local acute services to train staff as falls champions. Regular audits of falls were on-going with feedback to staff on results by the person in charge. Quality improvement action plans were put in place to prevent recurrence.

Residents were provided with medical care and health and social care professional interventions as they required, with some further improvements identified as described in Regulation 6. Residents had access to medical care services including general practitioner (GP), psychiatry of old age and health and social care professionals. There was evidence of medical reviews and reviews by other allied health and social care professionals, both by phone and in person.

A comprehensive risk management policy, risk register and a risk management committee were in place which included control measures for identified risks. However, the inspectors found a number of risks on the day that had not been identified, assessed or mitigated by the provider. As a result, an immediate action plan was issued in respect of fire safety and safe storage of residents' records. The risks were mitigated by the person in charge and the director of operations prior to the end of the first day of inspection.

Although inspectors observed many instances of good practice in respect of infection prevention and control, significant improvement was required in this area, the specifics of which are described under Regulation 27. Records showed that staff had received up to date training in COVID-19 precautions, prevention of the transmission of the COVID-19 virus and use of personal protective equipment (PPE) and demonstrated knowledge of the principles of training. However, the inspectors found

that the training was not fully implemented in practice in respect of standard precautions and guidance on wearing of face masks and environmental and infection control.

Staff, whose role and remit required it, received training in cleaning practices including the use of equipment and chemicals. A housekeeping handbook outlined the importance of good cleaning practices and the rationale and process for cleaning high risk frequent touch points in health care areas. However, inspectors found that, despite clear cleaning schedules and training, the standard of cleaning practice in some areas of the centre was not of a good standard.

The management of fire safety required further review. There was evidence that all staff were provided with training in fire safety and evacuation procedures, and an external provider was made available to staff for this training. Evacuation procedures to guide staff, residents and visitors in the event of a fire evacuation scenario were posted on the corridors of the centre and most residents were observed to have personal evacuation plans (PEEPs) in their bedrooms. However, inspectors found that the fire evacuation procedures as listed above required review to ensure that all residents could be safely evacuated from the centre in a timely manner in the event of a fire.

Regulation 11: Visits

Visiting was facilitated in line with the latest COVID-19 guidance issued by the Health Surveillance and Protection Centre (HPSC). Residents were supported to receive visitors in their bedrooms, in one of the outdoor spaces or in a designated visitors' room on the ground floor. A number of visits were observed to be taking place over the two days of inspection, and residents' feedback was positive in relation to same.

Judgment: Compliant

Regulation 17: Premises

The care environment and facilities available did not fully meet residents assessed needs in line with the centre's statement of purpose or conform to all of the matters as laid out in Schedule 5 of the regulations, in that:

- Storage facilities in the centre required full review to support the implementation of appropriate infection prevention and control procedures.
- Appropriate and safe staff change room facilities were not provided.
- A number of items of equipment required maintenance, repair or replacement.
- A fire door was in need of repair on one unit.

- Signage to identify the use of each room in the centre was not in place and orientation signage, for example on communal bathrooms, was inconsistent throughout the premises.

Judgment: Not compliant

Regulation 26: Risk management

The oversight of risk management required improvement to ensure all potential risks in the centre are identified, and appropriate controls are in place to control these risks. Inspectors identified risks that were not risk assessed or included on the risks register including risks associated with free-standing oxygen cylinders and fire risks.

Judgment: Substantially compliant

Regulation 27: Infection control

Areas where infection prevention and control practice was not consistent or posed a risk of spreading infection were found and improvements were required including;

- Improvements in the overall environmental cleaning were needed as there was evidence that not all areas and facilities in the centre were cleaned thoroughly or regularly; for example the cleaning room facilities
- The hygiene of cleaning equipment required full review, as some unclean equipment was observed in residents' en-suite and sluice rooms. This included wash hand basins, unhygienic mop buckets and mop heads
- The decontamination of equipment was not at an appropriate standard.
- The tag system in place to support staff identify whether communal equipment such as slings, or hoists had been decontaminated was not consistently implemented in practice
- The storage of items on the floor did not promote appropriate sanitisation, including personal protective equipment (PPE), residents' and staff personal belongings and residents' continence wear.
- Clinical wash hand basins required review to ensure they were of correct specifications, readily available in areas where they might be required and in line with best guidance in infection prevention and control.

Judgment: Not compliant

Regulation 28: Fire precautions

Inspectors were not assured that adequate precautions against the risk of fire were in place and an immediate action plan was issued on the first day of inspection in relation to:

- Stairwells being used as temporary staff changing facilities
- Storage areas under the stairwells were being used to store flammable materials, including decorations and historical residents records, without appropriate fire safety equipment in place
- Access to emergency evacuation equipment in some stairwells was restricted by equipment

The inspectors were assured that these risks were addressed and mitigated by the provider prior to the end of the first day of inspection.

In addition, inspectors found that there was insufficient signage in place to identify where highly flammable materials, such as oxygen canisters, were stored.

Further assurances were required to ensure adequate arrangements were in place for the timely and safe evacuation of all residents and staff including simulated full evacuation of large fire compartment areas with the lowest level of staff available. Additionally, assurances including a review and risk assessment of all fire compartments, by a competent person, to ensure appropriate containment measures were in place and that fire compartments are of a suitable size to ensure the safety of all persons.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Inspectors looked at a sample of comprehensive assessments and care plans in place for residents. Considerable improvements were required to ensure that all residents were receiving a high standard of evidence based practice. Examples include:

- Comprehensive assessments prior to admission were not fully completed in respect of some residents to enable an informed decision be made on whether the provider had sufficient and suitable resources to fully meet the needs of some residents. There was evidence that the full needs of some residents were not met as a result.
- A risk assessment or care plan was not in place for every identified need.
- Care plans were not always updated to include health and social care professionals inputs.
- Daily nursing records were repetitive and did not give sufficient insight into the overall health and well-being of residents.

Judgment: Not compliant

Regulation 6: Health care

Improvements were needed to ensure that where additional clinical expertise was required to manage residents with complex needs, that this was accessed in a timely manner.

For example, where residents were referred for review to primary health care services, it was not always evident that these referrals were followed up by staff in a timely manner. Also, although there was good access to physiotherapy services, it was noted that where one resident was prescribed an exercise programme, there was no evidence available that staff were supporting the resident to complete same, despite a deterioration in the residents' mobility or functional status.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

There was a low use of restraint in the centre and this was appropriately notified to the Chief Inspector. Inspectors observed that where a restraint was in use, an appropriate risk assessment and care plan was in place.

Staff were knowledgeable of person-centred interventions to trial if residents presented with responsive behaviour, including validation techniques, distraction methods, using simple language and continuously showing the resident respect and dignity.

Judgment: Compliant

Regulation 8: Protection

There was a safeguarding policy in place and staff had participated in training.

Staff spoken with had a good knowledge of what constituted abuse and what they would do if they witnessed any form of abuse.

The person-in-charge conducted an in-depth review following an incident where concerns were raised. There was evidence that subsequent to the review, improvements to processes in place were made to further assure residents safety

and protection

Judgment: Compliant

Regulation 9: Residents' rights

Inspectors found that some households did not provide sufficient opportunities for residents to engage in meaningful activities. This was a finding on the previous inspection and had not been addressed effectively by the provider. For example:

- One household did not have staff available to implement the activity programme.
- Some residents were not informed that a religious service was taking place in the oratory on the first day of inspection and therefore did not have the opportunity to attend
- A number of residents told inspectors that they felt bored and that they were not informed of any activities taking place in the centre
- A group exercise class was observed to have been interrupted a number of times due to the staff member being required to answer phone calls and facilitate visits. This was observed to have a significant impact on residents' engagement and enjoyment of the activity
- A group exercise class consisting of a video demonstration and a staff member providing additional instruction was not suitable for all residents' abilities and the inspectors observed that residents spent periods of time without being able to participate. This resulted in one resident becoming frustrated as staff did not adapt the exercise to ensure that they could take part.
- Some care practices and the use of institutional language found on inspection did not demonstrate respect for residents as individuals; for example residents were not always offered choice in the drinks they would like to take with their meals; the inspectors also observed two occasions where staff did not respond in a timely manner to residents' requests to go to their bedroom or use the bathroom
- Access to outdoor space for the residents living on the upper floors was restricted and dependent on staff availability

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Not compliant
Regulation 21: Records	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	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	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Moorehall Lodge Drogheda OSV-0000737

Inspection ID: MON-0033451

Date of inspection: 16/07/2021

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: The Number and skill mix of staff on the rosters are monitored in conjunction with the resident's needs using the Modified Barthel Dependency tool. In each household, A training needs and gap analysis is completed by the PIC and the Training Co-Ordinator to identify training gaps and complete training plan to ensure any identified training gaps are completed. Aggressive recruitment continues to be actioned as a priority. Increased usage of agency staff as an interim measure to fill vacancies and gaps in rosters. The Housekeeping lead is facilitated to monitor and ensure that quality control on cleaning practices is completed daily. When there are unplanned absences, all efforts are made to fill that vacancy including the completion of a risk assessment to facilitate a staff member moving from another household. Only staff that have completed the basic food hygiene course and the training on the use of chemicals are permitted to work in the homemaker role. Weekly meetings occur with the HR team to highlight any gaps in the roster due to unplanned sickness and the measures placed to reduce these gaps in future. Group HR are in collaboration with the local HR team to support with current recruitment needs. There is a targeted focus approach to attract senior HCAs to complement and enhance the skill mix of the current team in MHLD. Additional marketing budget allocated to push recruitment adverts with an aggressive daily social media campaign to cover nursing, HCA, and ancillary positions is in place since 24th August 2021. This additional recruitment campaign will run alongside our normal recruitment channels to drive volume applications. Group HR provide additional support to the local HR team to assist with immediate interviewing across all disciplines to ensure that the highest quality talent is delivered to within the shortest time-period possible. The HR Team attends weekly clinical governance meeting since 14th August 2021 to address Recruitment and staffing issues in a timely and pro-active manner.	

Responding to nurse vacancies with a blended recruitment approach; pipelining international nurses and interviewing local staff nurses. Moorehall Lodge Drogheda continues to liaise with Overseas Recruitment Agent to ensure a pipeline of staff nurses. Targeted Advertising Campaigns also initiated aimed at attracting local nurses to reduce reliance on overseas nurses and to establish relief panel and augment staff nurse capacity to cover short term and unplanned absences

- MHLD have advertised to recruit the following Senior Managers to enhance the leadership and supervisory capability within Moorehall Lodge Drogheda:
- An additional 1 WTE Assistant Director of Care role/Care Manager bringing the total number of care managers in the centre to 3 WTE
- A new role – 1 WTE Clinical Nurse Manager with overall responsibility for Infection Prevention and Control.
- A Relationship Manager commenced in Moorehall Lodge Drogheda on August 9th and role and function will include the completion of the pre-admission assessments and will assist in the training and the roll out of the Butterfly approach programme. This role will also offer additional support to the management team in MHLD given the Care Manager experience the relationship manager has held previously and will participate and facilitate in onsite training.
- The HR and Management team will monitor weekly sick leave reports to enable swift and appropriate action to have any absences filled were reasonably practical. Notwithstanding the above there will continue to be last minute and/or unexpected absences and through the focused HR drive currently been undertaken it is planned to establish a Relief Panel to augment HCA capability to fill such gaps and reduce reliance on agency.

To aid in the ongoing management and monitoring of absenteeism a return-to-work meeting will occur following every absence which will aid identifying corrective action or supports required around same.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Supervisory and monitoring training will be provided for all nurses in MHLD by 30th October 2021.
Performance management, supervisory and monitoring training will also be delivered to the management team in MHLD by 30th September 2021.

A program of in-depth manual handling audits will be completed in each of the Households in MHLD by 02/09/2021.

Each manual handling audit has a corresponding Quality Improvement plan which will be communicated to all members of MHLD via Team meetings, Nurses meeting and Social, Clinical and Transition meetings.
The manual handling auditor also completed "on the spot" coaching and refresher training with different staff members in relation to the different manual handling techniques and the use of the appropriate manual handling equipment required such as walking belts, slide sheets when repositioning/assisting a resident from sit to stand position.

All members of Housekeeping and Homemaking staff will have completed their training program by week ending 04th September 2021.
The training provided to these groups of staff include the following:

- The training included cleaning policy with cleaning method statements and Safety Data Sheets. Completed by 04/09/2021
- Housekeeping lead directed to review and observe cleaning methods used and ensure completion of task training.
- Review of Safety Data Sheets completed on 31/08/2021 including the location and accessibility of Safety Data Sheets.
- Cleaning Policy Reviewed and updated as of 17/08/2021.
- The updated Checklist Identifies for Cleaners which equipment to tag as of 24th August 2021.
- Homemakers Mop Closet now included on Homemakers cleaning checklist as of 26th July 2021.
- All mops and housekeeping rooms were deep cleaned by 28th July 2021.There is a cleaning schedule for the housekeeping rooms
- All existing Carers have received training on the use of bed pan washers. The use of bed pan washing machine is also included on the revised Induction checklist for all new members of staff effective from 26th July 2021.
- An additional storage container was sourced on 18th July 2021 where the PPE is now stored.

Housekeeping lead has received training and support in relation to the supervision and monitoring of housekeeping practices and standards of cleanliness. Completed on 31/08/2021.

In House Induction program continues to be scheduled monthly which will be evaluated in relation to its effectiveness via staff feedback and via observational audit.
Competency Handbook for Registered Nurses and Carers is currently under review and will be completed by 30th September 2021 to ensure full understanding and knowledge on roles and responsibilities. The competency handbook will then be signed off by the appropriate manager.
A revised Fire Induction checklist is completed for all new starters ,effective from 23rd July 2021.
A revised Induction checklist for all new starters was completed and updated, which now includes the use of the bed pan washer.
All existing staff have received training on the use of bedpan washer, which was completed on August 20th 2021.
Infection prevention control training has been provided for the new starters and the

refresher course for the existing staff including HSE online and practical training completed by 01/09/2021
In house Falls management training and the safeguarding training has been provided to all staff members and completed 01/09/2021 .

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Prior to and following the inspection a review of the following areas was completed :
• Alignment to Group wide governance structures.
• Centre Management capacity
• Performance management
• Risk management, Audit and continious improvement

Following completion of this review, there was an acceleration of alignment to the Group wide governance structures including, the Group HR Committee, and Group Executive Management Team providing overarching governance.
The RPR Chairs Weekly follow up meetings which have been actioned since 27th July 2021 and is attended by the Group and the local management team in MHLD.Meetings are minuted and actioned .
At centre level, local management capacity has been strengthened with the addition of A third care manager. This will increase and strengthen the oversight ,monitoring and supervision of clinical practice in MHLD.

A Social Care Manager will be commencing in MHLD by 30th September 2021.
The Introduction of the Advanced Care practitioner's role will provide and increase the monitoring and supervision of delivery of person-centered care, including the mentorship of newly recruited care staff to MHLD commencing 01.10.21

PIC and Care Managers have received training and education in relation to regulatory compliance, legislation, and completion of audits. Completed on 01st September 2021.

In house Induction program is continued for all new starters on the monthly basis.

Daily quality assurance checklist is completed by care managers in their assigned households. This checklist is designed to help care mangers to document the supervision and coaching provided to the staff activities in each assigned household.

External Audit was completed by the organization which reviewed the governance structure, systems, and processes and to ensure effective monitoring. An action plan is being developed from the results with ongoing monitoring.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
A full review of all MHLD written policies and procedures including COVID policy will be completed by 30/09/2021.
Following completion of the review all policies and procedures will be rolled out to all new and existing staff members with the appropriate polices and procedures pertinent to their role and responsibilities.
Policies and procedures are included on the induction program for all new staff effective from 05th August 2021.
All newly recruited staff during their induction and supernumerary hours will complete the reading and signing indicating that they have read and understood all the policies and procedures in MHLD.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Audit of resident's care plans including the person-centered interventions were completed by 31st July 2021.
All registered Nurses currently working in MHLD have received training "Documentation in Clinical Practice". This training was completed on 25th August 2021.
Care managers monitor and oversee the input from the Allied Health Professionals to ensure that all the updated detail is included in residents progress notes and care plans. This action commenced on July 21st 2021 and is ongoing.
The PIC completes post admission audits 48 hours post admission of a resident to MHLD. The post admission audit includes a review of the pre-admission process, clinical risk assessments and that the appropriate care plans are prepared based on the resident's comprehensive assessment.
The newly appointed Relationship manager is aware and has good working knowledge of MHLD pre -admissions assessment tool and the admissions policy and procedure.
Weekly Admissions meetings continue to take place with the PIC and the relationship manager in attendance.
A review of storage completed, and all residents' records are stored in a safe and accessible space.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Staff changing room areas have been reviewed following the inspection.
Each household team has a designated staff changing room that does not impact on residents and visitor private space.
A standard operating procedure for "Staff changing area" has been developed and same has been communicated to all existing members of staff by 23rd August 2021. This SOP is also included on the Induction program for all new starters.
The Fire door was repaired and is fully functional as of 26th July.
It has been reiterated to all staff members the need to promptly report equipment that is not in working order via the maintain x app. Facilities management including the planned preventative maintenance are monitored through local management team and Group wide Facilities Lead.
The Maintenance staff member attends daily Meetings with PIC and Care Managers to provides a status update on any items of equipment that are awaiting repair.

The hoist that was reported as non-functioning was reported on maintain x on 15th July and the commentary stated that a replacement remote control was ordered on 15th. On arrival of replacement this was immediately repaired, and the Hoist remains in working order since 20th July 2021.

Bed pan washers are currently all in good working order as of 01/09/2021.

Signage for the use of each room was not in place as part of the Household model of Care .However, signage will be placed on communal bathrooms and on the doors of sluice rooms and housekeeping rooms by 30th September 2021.

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
All oxygen cylinders are stored safely and securely within each clinical room in Moorehall Lodge Drogheda since 21st July 2021.
Weekly review of the Central risk register forms part of the weekly Clinical Governance meeting.
Risks are reviewed on an ongoing basis and a record of review is maintained in MHLD Central Risk register effective from 17th July 2021.
A Group Quality Safety and Risk manager has been recently appointed and expected date of commencement is 15th October 2021.

Risk management Training workshop will be provided by an external trainer for the senior Management team in MHLD by 30th October 2021.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Following the inspection an infection prevention and control audit was completed on 04th August 2021. A Quality Improvement Plan was developed based on the findings. This process is continuously monitored through weekly Centre & Group wide Governance processes including weekly meetings.
GSM has completed an in-depth training with all housekeeping staff and homemaking staff in relation to cleaning process and use of cleaning agents as mentioned under regulation15.
Job descriptions for Housekeeping and Homemaking have been reviewed on 10th August 2021.
The use of the bed pan washer is now included as part of the induction process for all relevant staff.
Refresher course of Infection control and prevention training has been and continues to be provided for all existing staff. Scheduled refresher training program is ongoing daily, and this is duly documented

· Advice and Guidance has been sought from Public Health in relation to the correct specifications of the clinical wash hand basins. The implementation of the plan to ensure that all clinical wash hand basins are of the correct spec will be completed by November 2021.
· Completion of works will be completed by 31st October 2021 for the 2 clinical wash hand basins that were identified on the day of inspection in relation to their accessibility.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
As part of the Fire Management Strategy for the nursing home a review is currently under way in MHLD and will be completed by 30th October 2021 which will include the review of all fire compartments.
Regular evacuation simulation drills have been completed and continue to occur including the Horizontal evacuation.
Records are maintained of each simulated fire evacuation drill including the length of time to evacuate a compartment, the scenario and the learning that was identified during

the simulation fire evacuation.

· New signage will be in place by 30th September 2021 to identify highly flammable materials oxygen stored.
· Updated fire induction checklist is completed for all new starters and for existing staff.
· Stairwells are not used as temp changing rooms.
· There is no Storage under stairwells.
· Access to emergency equipment in stairwell unrestricted

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:
All preadmission assessments are now completed in full because of the review and updated MHLD Admissions policy. All the relevant and appropriate supporting documentation that is required is received prior to acceptance of admission of resident to MHLD.

Any new admission that comes to live in MHLD, their clinical risk assessments, care plans are are completed within 48 hours of admission to MHLD.
This process is audited 48 hours post admission by the PIC to ensure full compliance with all the above is completed in full.
A Full review and audit of all required care plans and residents' individual assessments completed All preadmission assessments are audited and completed within 48 hours of admission to MHLD to ensure that all information was acquired as part of the preadmission process. All residents' individual assessments and care plans are audited within 48 hours of admission to MHLD to ensure that all are completed and include all the necessary person-centered interventions.
Any Gaps, improvements, and learning is identified, and a Quality Improvement Plan is developed. (QIPS) monitored through Centre and Group wide governance process including monthly Social, Clinical and Transition meeting and Executive Management team meetings and reports.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Training was completed for all registered Nurses on Documentation in Nursing.

When a resident has received a review from the Allied Health professional, the residents' records are updated. This action is the checked by the Care manager responsible for that household.
All residents who require additional clinical expertise, will be followed up with out delay by the PIC.
An audit of resident care plans to include audit of updated interventions from the AHP.
The PIC and Care Managers on arrival of duty complete an overview of clinical risks based on recorded priority entry to residents' notes.
When and if a GP has requested further follow up required, this will be appropriately recorded in the resident's progress notes.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
A review was completed post inspection including the process of communication the scheduled weekly activities. The weekly schedule of activities is displayed in all prominent areas in each household and in the resident bedrooms and is also communicated daily to each of the residents that live in Moorehall Lodge Drogheda.
This is monitored through social and recreation audits, resident feedback, and delivery of social program at Household level.
Resident feedback is provided at the documented weekly learning circles in each of the households.
External Providers have been sourced who attend MHLD weekly since 29th July 2021 to provide a social and exercises for the residents in MHLD.
Unannounced Observational audits will be completed on an ongoing monthly basis by the Director of Operations commencing Week 31st August 2021, focusing on the lived experience of the residents and the delivery of person-centered care.
PIC will also complete unannounced observational audits in each household using the QUIS audit tool.
Following completion of the induction period, The Social Care Manger will be involved in the admission process of the resident to MHLD so that the prospective residents' hobbies interests, the residents' strengths and abilities will assist the Social Care Manger in the development of an individual person centered social and well-being plans.

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	30/10/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Yellow	30/09/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/09/2021
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre,	Not Compliant	Orange	30/09/2021

	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.	Substantially Compliant	Yellow	30/09/2021
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Yellow	18/07/2021
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	30/10/2021
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	30/09/2021
Regulation 26(1)(a)	The registered provider shall ensure that the risk management	Substantially Compliant	Yellow	30/10/2021

	policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.			
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.	Substantially Compliant	Yellow	30/09/2021
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	30/10/2021
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/10/2021
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and	Not Compliant	Orange	30/10/2021

	building services.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	30/09/2021
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	30/09/2021
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Not Compliant	Yellow	30/09/2021
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	Not Compliant	Yellow	30/09/2021

	best practice.			
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	30/09/2021
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	Yellow	30/07/2021
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	Yellow	30/08/2021
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5,	Substantially Compliant	Yellow	30/09/2021

	provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.			
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Substantially Compliant	Yellow	30/08/2021
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	30/09/2021
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	Substantially Compliant	Yellow	30/08/2021

	the rights of other residents.			