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:	20 September 2022
Centre ID:	OSV-0000072
Fieldwork ID:	MON-0037436

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:	37

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 20 September 2022	09:20hrs to 17:55hrs	Helena Budzicz	Lead
Tuesday 20 September 2022	09:20hrs to 17:55hrs	Brid McGoldrick	Support
Monday 3 October 2022	10:30hrs to 17:00hrs	Gordon Ellis	Support
Monday 3 October 2022	13:30hrs to 17:00hrs	Manuela Cristea	Support

What residents told us and what inspectors observed

Inspectors arrived at the centre in the morning to conduct an unannounced inspection. Over the course of a two-day inspection, completed between 20 September 2022 and 3 October 2022. Although the provider had made significant improvements since the last two inspections, particularly in relation to infection control, resident's rights and medication management, inspectors found that more focus and resources were now required to bring the designated centre into compliance with Regulation 28: Fire precautions, Regulation 23: Governance and management and Regulation 17: Premises.

Inspectors met with all of the 38 residents living in the centre and spoke with five residents in more detail to gain insight into their experience of living in the centre. Residents were generally positive about the care and support they received. Inspectors observed interactions between the staff and residents throughout the day and found staff were observed to be responsive and attentive towards residents. However, inspectors noticed an incident when staff used incorrect manual handling practices despise being corrected by the management of the centre.

Following an opening meeting with the person in charge, the company director and the newly appointed assistant director of nursing and general manager, inspectors walked through the centre and met with residents and staff. Inspectors saw some residents up and ready for the day, and some were mobilising around the centre. Others were in their bedrooms receiving their breakfast or personal care. Staff were seen to be busy assisting residents and attending to residents' call bells.

An ongoing programme of maintenance works had resulted in a number of bedroom doors being renovated. Inspectors saw a workman in residents' rooms using a drill at mealtimes, causing large dust clouds in residents' bedrooms and corridors and increased noise from ongoing drilling. While the provider advised that one of the residents impacted was in agreement with the work, the resident was not offered a protective mask to reduce the effects of dust inhalation or to be relocated from the room during the time of ongoing work.

Many visitors were seen coming and going on the day, with visits taking place indoors in residents' rooms, communal areas and outside. Inspectors observed that residents had unrestricted access to an enclosed garden.

The inspectors saw that meals being served in the centre appeared wholesome and varied, with adequate portions being served. Staff knew residents' preferences and routines, and these were facilitated in a caring manner. Residents had a choice of where to have their meals throughout the day.

Inspectors observed that staff wore face masks while providing direct care to residents. Alcohol-based hand gel dispensers and personal protective equipment (PPE) were readily available along all corridors for staff use. However, inspectors

noticed staff entering and leaving the kitchen without the appropriate protective clothing worn.

The following sections of the report detail the findings with regard to the capacity and management of the centre and how this supports the quality and safety of the service provided to residents.

Capacity and capability

This was an unannounced inspection that was carried out following receipt of representations from the registered provider, Moyglare Nursing Home Limited, in relation to a proposed notice of decision issued by the Chief Inspector. The proposed notice included two restrictive conditions. One condition specified a maximum occupancy of 38 residents and proposed to stop admissions to the centre until required improvements were made to ensure the service was safe, appropriate, consistent and effectively monitored while requiring the provider to take all necessary action to address the identified issues and demonstrate sustained compliance with the regulations. Another condition specified the need to strengthen the governance and management structures, the staffing model and the clinical oversight. In their representation, the provider had submitted information to the Chief Inspector to state they had addressed many of the non-compliances identified in the centre and successfully recruited a new management structure to strengthen managerial oversight of the centre and address the outstanding issues.

Inspectors found that the oversight and governance arrangements in the designated centre did not ensure that safe and appropriate care and services were provided for all residents accommodated in the centre. Changes have been made to the centre's organisational structure since the last inspection, and the new management team has been proactive in responding to most findings on previous inspections. However, inspectors found that improvement to resources and management systems was required to improve the safety of residents. In particular, the systems in place with regard to premises, fire safety and governance and management oversight.

The registered provider for this designated centre is Moyglare Nursing Home Limited. The new management team consisted of a person in charge, an assistant director of nursing and a general manager who had recently been recruited to these posts. However, inspectors found that there was ambiguity among staff and the management team regarding the reporting structure in the centre. The inspectors sought clarity in respect of the roles, lines of authority and accountabilities within the management structure in the centre. The provider informed inspectors that this management structure was to change again in the near future when a new person in charge was appointed.

There was a new, improved audit system in place to monitor the centre's quality and safety. Inspectors saw evidence of a comprehensive and ongoing schedule of audits in the centre, for example, nursing documentation, infection prevention and control,

and medication management. Audits were objective and identified improvements. However, some improvements were required to identify specific timelines required to achieve compliance and the person responsible for a follow-up review.

There were adequate numbers of staff in the centre on the day of inspection to meet the needs of residents. However, assurances were required following a review of the roster and the statement of purpose, which is outlined further under Regulation 15: Staffing. Inspectors were informed that the provider had an ongoing recruitment programme in place.

Inspectors found that overall oversight and access of staff members to training improved since the last inspections; however, staff knowledge and supervision in clinical practices required further improvements.

Records and documentation required under Schedules 2, 3 and 4 of the regulations were securely stored and generally maintained in good order. However, some of the records were stored in the attic, which was not registered as part of the centre, as required under the Health Act 2007, as amended. Additionally, the staff files required review as addressed under Regulation 21: Records.

Regulation 15: Staffing

The level of staff on the day of the inspection was adequate to meet the assessed needs of the residents residing in the centre on the day of the inspection. However, a review was required to ensure that the provider will provide sufficient resources and appropriate staffing levels, having regard to the needs of residents when reaching full occupancy and considering the size and layout of the centre.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Training records were provided to the inspectors for review and indicated that there was an active training schedule in place, and most of the staff completed appropriate training and other training relevant to their role. However, while the general manager appeared to have good oversight of what training staff had attended, management needed to ensure that staff members improved their knowledge in respect of completing nursing assessments, care planning and restrictive practices.

Judgment: Substantially compliant

Regulation 21: Records

The inspectors reviewed six staff files and noted that four staff files did not contain all information as required by Schedules 2 and 4 of the regulations. For example, written references from a person's most recent employers, the dates when the staff commenced the employment, and one evidence of the person's identity was missing.

Judgment: Substantially compliant

Regulation 23: Governance and management

The inspectors found that further action was required to ensure the quality systems in place monitored key areas of the service and facilitated quality improvements for the residents. For example,

- While the management structure in place was clearly defined, the reporting system required clarification as staff challenged the communication of roles and responsibilities of the new management team.
- Inspectors observed that the attic space was used for storage purposes, and bedroom 15 was converted to office space. These changes had not been reflected in the centre's statement of purpose or communicated to the Chief Inspector. The provider had not submitted an application to change the conditions of the registration, as required under the Health Act 2007, as amended.
- While the new audit schedule was in place and accurately identified the areas of improvement with proposed actions to be taken, the timeline of completion and review, if the improvement and actions were correctly addressed, were missing.
- The provider failed to identify risks associated with works being carried out in residents' rooms and to put measures in place to mitigate the risk of noise and dust.
- Oversight of residents' assessed needs and care plans required improvement, as evidenced under Regulations 5 and 6.
- The registered provider had not ensured effective governance arrangements were in place to ensure the sustainable delivery of safe and effective infection prevention as outlined under Regulation 27: Infection Control.
- Management systems, which monitored fire safety and the residents living environment, failed to respond to identified risks as addressed under Regulation 28: Fire precautions.

Judgment: Not compliant

Regulation 31: Notification of incidents

While notifications were submitted within the specified time frames and as required by the regulations, quarterly reports submitted to the Chief Inspector did not include the use of chemical and environmental restrictive practices.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The centre's medication and pain management policy and procedures, as outlined in Schedule 5 of the regulations, were up-to-date and available in the centre.

Judgment: Compliant

Quality and safety

Overall, the findings showed that on the day of inspection, the provider was committed to deliver good quality care and support to residents. However, inspectors found that while some action had been taken since the previous inspections by the provider to address areas of non-compliance, significant action was required in the management of fire safety and premises to promote residents' safety at all times.

On the day of the inspection, the residents were observed to be well-groomed and neatly dressed. Observation showed that staff actively engaged with residents and interacted in a nice and polite manner.

There was evidence of good consultation with residents, timely access to healthcare services, and opportunities for social engagement. The inspectors reviewed a sample of residents' files, and there was evidence that the resident's needs were being assessed using validated tools. However, inspectors saw that the staff did not follow up guidance on the nursing assessments, resulting in residents not receiving adequate personal equipment as evidenced under Regulation 6: Healthcare.

While inspectors acknowledged that staff were continuously updating and reviewing care plans in the centre to ensure adequate oversight, some work was required to minimise the risks associated with the staff's understanding of residents' identified needs to appropriately inform and navigate staff practices.

Generally, infection control processes and cleanliness of the centre have improved since the previous inspection; however, some outstanding issues were highlighted under Regulation 27: Infection control.

The registered provider had commenced an improvement plan in respect of premises, such as painting bedroom doors and redecorating and painting the communal rooms, which would improve the quality of life for the residents. However, further improvements were required, as evidenced under Regulation 17: Premises.

From a fire safety perspective, the provider had good oversight of the fire issues in the centre. A fire safety risk assessment was carried out along with a fire door report by the provider due to the findings of a previous inspection. The provider received the finished report at the end of September and informed the inspectors of a six-month plan to address the fire issues identified. The provider had made some progress in addressing fire safety issues with respect to fire doors, emergency lighting, detection and evacuation aids. Staff spoken within the centre were very familiar with and knowledgeable about fire evacuation procedures. The majority of fire documentation reviewed by the inspectors was up-to-date, with faults recorded and acted upon. Nevertheless, fire issues were identified by the inspectors and further improvements were required by the provider to bring the centre into compliance, as evidenced under Regulation 28: Fire Precautions.

Inspectors acknowledged that the provider increased the quality of life for residents residing in the twin-occupancy bedrooms and offered them single-occupancy bedrooms. Staff who spoke with inspectors reported that residents' cognitive and social engagement positively improved since they resided in the single-occupancy bedroom. Nevertheless, further review was required to review twin-occupancy bedrooms and determine if they would meet the requirements of S.I. No. 293/2016 - Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations 2016 for use as twin rooms going forward. All twin-occupancy bedrooms were unoccupied on the day of the inspection.

Regulation 17: Premises

The inspectors acknowledge that the provider has improved the premises since the last inspection of this centre. However, parts of the premises did not conform to the matters set out in Schedule 6 of the regulations, for example;

- There was a broken toilet paper holder with sharp endings in one of the resident's bathrooms, posing a risk of injury for the resident.
- The temperature in the centre required a review as the radiators were scorching, posing a risk of scolding. The temperature in the drug room was 26.8 degree Celsius on the day of the inspection and was continually above 25 degrees since the start of January, which was not safe for some of the medicine storage.

- There were holes in the wall in the linen room, posing a risk for pest control.
- There were four bedrooms with bathrooms with shower corner in the centre that was not accessible for residents with increased mobility needs due to the layout of the en-suite space.
- In St. Martha and St. Pio Units of the centre, there were insufficient assisted toilet facilities in close proximity to residents' bedrooms to ensure a ratio of at least one assisted toilet to eight residents, as required by the SI. 293 amendment to regulations. Furthermore, in St. Martha, there was only one assisted shower/bathroom facility for 14 residents.
- The registered provider did not ensure that the premises of the designated centre were appropriate to the number and needs of the residents and in accordance with the statement of purpose.

During the walkabout of the premises, the inspector identified a number of discrepancies between the floor plans, the description of facilities in the statement of purpose and the physical environment.

- The St. Anthony Unit had four bedrooms with en-suite shower facilities, which could only meet the needs of mobile residents.
- One designated bedroom had been converted into an office. The provider was requested to review and resubmit amended floor plans and statement of purpose to reflect these and include all areas of the designated centre, including the top floor where offices were located.

Judgment: Not compliant

Regulation 27: Infection control

The inspectors were not assured that equipment was decontaminated and maintained to minimise the risk of transmitting a healthcare-associated infection. For example:

- Assistive equipment such as shower chairs, nebuliser masks, wheelchairs, and seat cushions used in the centre and examined by the inspectors appeared visibly unclean. The current cleaning system in place did not ensure that equipment was cleaned and decontaminated after each use.

Inspectors observed that some practices and items were not clean, which did not support a safe environment that minimises the risk of transmitting a healthcare-associated infection. For example:

- Some staff were observed to adhere to poor practices in respect of personal protective equipment (PPE). For example, three staff were observed walking into the kitchen area without appropriate PPE.
- There were unlidded bins in clinical waste.
- The same blood pressure monitor cuff was used for residents with infection.

- Some doors and furniture were observed to be unclean and stained.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider had failed to take adequate precautions against the risk of fire in the centre and to ensure that residents were protected from the risk of fire. For example:

- There was inappropriate storage under a staircase that led to attic space and also in a cupboard where an electrical panel board was located. The provider was required to immediately remove the storage from the electrical cupboard and also from under the staircase.
- Hoist batteries were found to be charging in room 15 surrounded by cardboard boxes.
- A staff smoking area required a fire extinguisher and fire blanket. The same fire fighting equipment was also required in the residents' external smoking area.

Emergency lighting in the centre required a review by the provider. For example:

- Fire exit signage was missing above a fire exit door in a sitting room.
- New emergency lighting had been fitted both internally and externally. However, above two external fire exits, emergency lighting was missing. This required further review.

Arrangements to maintain the means of escape and the building fabric were not effective. For example:

- A hoist stored along a corridor used as a means of escape presented a trip hazard and potentially could affect the flow of evacuation in the event of a fire emergency.
- The inspectors found full-width curtains over fire exit doors. The curtains were pulled back on the day of the inspection; however, the facility was present to pull the curtains across the door and block the fire exit. Curtains placed above all fire exits required a review.
- A gate located in a courtyard was locked. As a result of this, a fire exit from this area was not readily openable to residents and staff in the event of an evacuation from this area. This was identified in the centre's fire safety risk assessment, and the provider was aware of it.

The building fabric was noted by the inspectors to be compromised in a number of areas. For example:

- The inspectors noted that attic hatches located in the ceiling were not fire-rated to ensure the integrity of the fire-rated ceiling.

- Breaches through walls and ceilings in areas of the centre required fire sealing to maintain the integrity of the fire-rated construction, for example, in toilets, storage rooms, laundry room and a bedroom.

The containment measures were noted by the inspectors to be compromised in a number of areas. For example:

- The inspectors were not assured of the integrity of the fire doors throughout the centre. This was evidenced by gaps found underneath fire doors along corridors. A fire door was not fitted to an internal gas boiler room, bedroom and kitchen doors were missing smoke seals, recently added smoke seals were not fully secured and required attention, some screws were missing from door hinges, and holes in fire doors needed filling due to new door handles having been recently fitted. Furthermore, doors to storage rooms did not have suitable fire-rated ironmongery and were missing fire seals and door closers. All of which compromised containment measures of smoke and fire in the centre. The provider had a fire door assessment carried out and had made progress to bedroom doors in the centre.
- The inspectors were not assured by the level of compartmentation in the registered centre. The centre did not have 60 minutes rated compartmentation suitable for progressive horizontal evacuation. Currently, the centre consists of 30-minute sub-compartments only. Information provided on the day of the inspection outlined that not all of the sub-compartments align with corridor fire doors. This resulted in a compartmentation deficiency and compromised the fire evacuation strategy. This was also identified in the fire safety risk assessment carried out in August 2022.

Arrangements for evacuating residents required improvement:

- Residents' evacuation requirements were assessed in the form of a personal emergency evacuation plan (PEEP). On day one of the inspection, the assessment did not take into account the mobility needs of residents at night time and also if residents were in receipt of medication, such as night sedation which might delay awakening from sleep and in an evacuation in an emergency.
- On day one of the inspection, one fire drill had taken place since the previous inspection. The evacuation time and residents involved were not indicated on the fire drills reviewed by the inspectors. There was also no record of fire drills with night time staffing levels being undertaken. The drills reviewed were not comprehensive and did not inform learning outcomes.

The procedures to be followed in the event of a fire displayed in the centre required improvement.

- While fire action notices and floor plans were displayed in the centre, floor plans did not accurately show the current layout of the centre. Furthermore, floor plans did not indicate the extent of compartments and sub-compartments that were suitable for progressive horizontal evacuation.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

From a review of a sample of care plans, inspectors found gaps in care planning arrangements as follows;

- The assessment of the dependencies of the residents was not accurate, and as a result, they did not inform the residents' care plans.
- Mobility care plans were not appropriately updated with recommendations from physiotherapists.
- The care plan for the end-of-life interventions was not accurately updated to reflect the therapeutic interventions when the resident's condition deteriorated.
- Nursing assessments were also not updated when the residents experienced deterioration in their condition and their nutritional, mobility, and personal care needs changed.

Judgment: Substantially compliant

Regulation 6: Health care

While the risk assessment tools for the prevention of pressure ulcers were completed, the data from the assessment was not followed up as indicated in the assessment guide, which resulted that residents with high risks of skin breaks did not have appropriate specialised equipment in place such as a specialised pressure relieving mattress, which posed a risk to the skin integrity of residents associated with complications such as pressure ulcers, moisture lesions, skin tears, and infections.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

The restraint register was not updated to reflect and monitor environmental and chemical restrictive practices used in the centre. This was a finding from the previous inspection.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents' rights to choice, privacy and dignity were respected in the centre. Residents' social activity needs were assessed, and their needs were met with access to a variety of meaningful individual and group activities.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Inspectors followed up on issues found on recent inspections and found that these had been resolved. Significant improvements were noted in the medication transcribing practices, correct medication dosages and maximum dosages for PRN (as required) medication. The controlled drugs register was maintained in accordance with professional guidelines, and the balances of these medications were accurate.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant

Compliance Plan for Moyglare Nursing Home OSV-0000072

Inspection ID: MON-0037436

Date of inspection: 03/10/2022

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: A review of sufficient staffing level was completed Part 1 SOP (37 to 46 resident occupancy) and Part 2 SOP (46 to 53 resident occupancy) submitted to HIQA. In this review, it included the following; • Admission protocols which were updated in the Statement of Purpose • Assessment components • Proposed date of admission • Responsible Person(s) • The use of evidence framework in determining safe staffing requirements • Use of Rhys Hearns Dependency Tool in determining the correct staffing calculations based on residents' dependency and acuity. • The number of additional staff required identified when reaching 47-53 bed occupancy • Staging of Admissions with strong reference to the layout of the vacant rooms (room bed utilization) and further recommendations made with y HIQA in line Fire and Premised regulations. • Risk and Quality Management System involved in ensuring the level of compliance of safe staffing requirements with regulations and standards to be followed by the centre. • Staffing Recruitment protocols.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development:	

• Training records were provided to the inspectors for review and indicated that there was an active training schedule in place, and most of the staff completed appropriate training and other training relevant to their role. However, while the general manager appeared to have good oversight of what training staff had attended, management needed to ensure that staff members improved their knowledge in respect of completing nursing assessments, care planning, and restrictive practices.

• A training program will be developed and implemented in the area of nursing assessment, care plans, and restrictive practices specific to nurses. This will be outlined under the support training matrix. This will be facilitated by the General Manager. The training will focus on improving their skills and learning opportunities.

• After the training is completed, each nurse will be allocated with updating and reviewing the resident assessment, care plans, and specific to resident clinical risk assessment in the use of restraints and enablers. During this process, each nurse will be provided with mentorship and regular constructive feedback. The progress of each nurse and the development of resident comprehensive assessment and care plans will be monitored and addressed in the 2-level audit mechanism. This will be facilitated by the Deputy PIC and Senior Staff Nurse.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
• The written references from the most recent employers, dates of staff commencement of employment, and evidence of identity will be secured and provided for 4 staff members. This responsibility will be completed by the Registered Provider and General Manager.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• Communications to staff about the governance structure of the centre were facilitated during handover and staff meetings. Timescale: Completed 31/10/22

• The attic space was cleared of storage of items. Timescale: Completed 31/10/22

• HIQA application to 'Vary Condition' RE: Bedroom to Office and Show Office on first

floor. Floor plans and amendments to Premises and Fire will be incorporated. Timescale: 31/03/23

• Monthly 2 Level Audit summary report timeline of completion, improvement and actions addressed are now included. Timescale: Completed 31/10/22

• Risk assessments to mitigate the risks will be completed first prior to works carried out in the centre. Timescale: Completed 31/10/22

• Quality improvement plans specific to all resident's assessment and care plans will be put in place. Timescale: 31/01/23

• Quality service improvement plans specific to infection control and prevention and staff training will be implemented. Timescale: 31/01/23

• Current service improvement plans specific to Fire safety and standard already commenced on August 2022, in progress and will be completed in March 2023. Timescale: 31/03/23

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• All notifications specific to chemical and environmental restrictive practices will be notified to the Chief Inspector every quarter by the person in charge or registered provider as set out in the regulation.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Toilet paper holder was replaced. Timescale: Completed 31/10/22

• Room thermometers/digital thermostat will be placed in the units and corridors areas to monitor the temperature in the centre. This will be monitored daily by Deputy PIC and General Manager. Timescale: 31/12/22

• Specific to the room temperature in the in the drug room, a ventilation system in place to ensure temperature to be kept at below 25°C. Recording and monitoring of temperature is maintained. This will be checked daily by Staff Nurses, Senior Staff Nurse

and/or Deputy PIC. Timescale: Completed 31/10/22

• The holes in the linen room were fixed. Timescale: Completed 31/10/22

• The four (4) bedrooms in St. Anthony will be occupied with residents with low mobility needs, ensuring access to shower facilities. This will be incorporated in the assessment process prior to their admissions in the centre. Timescale: Completed 31/10/22.

• Under the refurbishment plan, another assisted bathroom facility will be constructed. Timescale: 31/08/23

• Refurbishment plan in progress in relation to premises and fire standards. Timescale: 31/08/23.

• HIQA application to 'Vary Condition' RE: Bedroom to Office and Show Office on first floor. Floor plans and amendments to Premises and Fire will be incorporated. Timescale: 31/03/22

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
The daily environmental audit tool will be carried out by the General Manager and Deputy PIC, this is to ensure that the current system put in place will be effective in decontaminating and cleaning the equipment after each use. There will be signing sheets for equipment cleaning to ensure the accountability of staff members.

• All staff entering the kitchen will wear white aprons. Aprons will be provided at the entrance door. Practices will be monitored by the General Manager and Deputy PIC.

• All clinical waste bins will be provided with lids.

• A new set of blood pressure cuffs will be provided and used for residents with no infection. Another set of blood pressure cuffs will be provided and used for the resident with infection. This will be properly labelled. This will be monitored by the Dep. PIC and Senior staff nurse.
Current refurbishment plans in progress by the Registered Provider such as residents' rooms functionality, improving the aesthetics of the environment, paintings, and replacement of furniture. This is to ensure that all areas are maintained in a good state of condition.

• Repeat Infection Control Training will be provided for staff for November and December, 2022 by the General Manager and Deputy PIC.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Electrical cupboard and staircase leading to attic space emptied. Timescale Completed. 20/09/22

• Hoist batteries moved to the charging point areas. Timescale: Completed 31/10/22

• Fire extinguisher and blanket provided in the staff smoking area and resident's external smoking area. Timescale: Completed 31/10/22

• Fire exit signage to be placed above fire exit door at the sitting room. Timescale: 30/11/22

• Emergency lighting above two external fire exits to be replaced. Timescale: 30/11/22

• Alternative safe storage area for hoist was identified. Timescale: 30/11/22

• Curtains were secured to prevent blocking the fire exit and fire doors. Timescale: 30/11/22

• Break glass unit will be fitted at the gate located in the courtyard. Timescale: 30/11/22.

• New fire rated attic hatches will be fitted in the ceiling. Timescale: 31/03/23

• Fire seals will be fitted in the walls and ceilings to maintain the integrity of the fire-rated construction. Timescale: 31/03/23

• Gaps in all doors identified in the report will be fixed to ensure containment measures for fire and smoke and works already commenced in August 2022.Timescale: 31/03/23

• 60 minutes fire doors ordered in October 2022, sub-compartments to be aligned with corridor fire doors. Once arrived on site will be fitted. Timescale: 31/03/23.

• All residents PEEP's were updated and reviewed incorporating the mobility needs, including specific medications during night time. Ski Sheets was purchased and provided to all residents' bed in Oct. 2022. Timescale: Completed 31/10/22.

• Regular fire drills for staff were conducted and scheduled in the centre. All fire drills include findings and recommendations. Records of Fire drills were maintained. Timescale: Completed 06/09/22

• Works to be completed first before floor plans can be updated. Timescale: 31/03/23

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
All residents' dependency clinical assessments will be reviewed and updated using Barthel Dependency tool. All resident's care plans will be updated and reviewed appropriately. Each nurse will be allocated equally by Senior Staff Nurse and Deputy PIC. Compliance and progress of completion will be monitored and addressed in the 2-Level Mechanism Audit system. A system of feedback to nurses will be in place.

• All residents' mobility care plans will be reviewed and updated incorporating the recommendations made by the physiotherapist. Each nurse will be allocated equally by Senior Staff Nurse and Deputy PIC. Compliance and progress of completion will be monitored and addressed in the 2-Level Mechanism Audit system.

• All residents' end-of-life care plans will be reviewed and updated to reflect the therapeutic interventions when the resident's condition deteriorated. Each nurse will be allocated equally by Senior Staff Nurse and Deputy PIC. Compliance and progress of completion will be monitored and addressed in the 2-Level Mechanism Audit system.

• All residents' nursing assessments will be reviewed and updated to reflect the actual resident's condition and their nutritional, mobility, and personal care needs. Each nurse will be allocated equally by Senior Staff Nurse and Deputy PIC. Compliance and progress of completion will be monitored and addressed in the 2-Level Mechanism Audit system.

• Specific staff training will be provided for all nurses in the areas of mandatory assessments and care plan development. Training portfolios, schedules, and other resources needed will be allocated and supported by General Manager, Deputy PIC, and Senior Staff Nurse.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
All residents' risk assessments for the prevention of ulcers will be reviewed by nurses. Each resident requiring specialized pressure relieving mattress will be provided. Procurement and supply of pressure-relieving mattresses will be facilitated by Registered Provider, General Manager, and Deputy PIC.

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:
The restraint register was not updated to reflect and monitor environmental and chemical restrictive practices used in the centre. This was a finding from the previous inspection.

• Specific to mechanical restraint, all resident risk assessments for the use of Enablers or Restraint will be reviewed and updated.

• Specific to chemical restrictive practices, monthly resident use of psychotropic medication audits will be implemented by nurses.

• Both will be recorded comprehensively in the Restraint/Enabler Risk Register and Resident Use of Psychotropic Medication Register. This will ensure appropriate recordings in the quarterly notifications to HIQA.

• Compliance and progress will be monitored in 2 level Audit by General Manager and Deputy PIC.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	31/10/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/01/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/01/2023
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and	Not Compliant	Orange	31/08/2023

	needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.			
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	31/08/2023
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	30/11/2022
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	Yellow	31/01/2023
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines	Substantially Compliant	Yellow	31/10/2022

	of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.			
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	31/03/2023
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	31/01/2027
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	31/03/2023
Regulation 28(1)(b)	The registered provider shall	Not Compliant	Orange	31/03/2023

	provide adequate means of escape, including emergency lighting.			
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	31/03/2023
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.	Not Compliant	Orange	06/09/2022
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/03/2023
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe	Not Compliant	Orange	31/10/2022

	placement of residents.			
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Not Compliant	Orange	31/01/2023
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.	Substantially Compliant	Yellow	31/01/2023
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	31/01/2023
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.	Substantially Compliant	Yellow	31/01/2023

Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, 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.	Substantially Compliant	Yellow	31/12/2022
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	31/12/2022
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	30/11/2022