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:	Moycullen Nursing Home
Name of provider:	Mowlam Healthcare Services Unlimited Company
Address of centre:	Ballinahalla, Moycullen, Galway
Type of inspection:	Unannounced
Date of inspection:	06 March 2023
Centre ID:	OSV-0000365
Fieldwork ID:	MON-0038588

About the designated centre

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

Moycullen Nursing Home is a purpose built facility located in Ballinahalla, Moycullen, Co Galway. The centre admits and provides care for residents of varying degrees of dependency from low to maximum. The nursing home is single storey in design and accommodates up to 53 residents. Residents are accommodated in 47 single bedrooms and 3 double bedrooms. Resident living space is made up of a large sitting room and a large dining room. In addition, the centre has a smaller lounge, a visitors room and an oratory. Residents also have access to an enclosed courtyard and gardens. The provider employs a staff team consisting of registered nurses, social care workers, care assistants, housekeeping and catering staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	50

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
Monday 6 March 2023	10:00hrs to 18:00hrs	Una Fitzgerald	Lead
Tuesday 7 March 2023	10:00hrs to 16:20hrs	Una Fitzgerald	Lead

What residents told us and what inspectors observed

Overall the feedback from residents was positive. Residents felt that the staff in the centre were kind and responsive to their care needs. Throughout the two days of inspection, the inspector observed a warm, friendly and welcoming atmosphere in the centre.

On entering the centre there is a large communal sitting room and a large dining room. This area was a hive of activity throughout the two days. The main reception area is situated between the two main rooms. This location is a gathering place for residents. Along the corridor there are a number of large armchairs for residents to sit and relax. On the days of inspection, the inspector observed multiple residents sitting in this area just relaxing or having a catch up with other residents.

The communal day room was a busy room with multiple activities happening. At one stage the inspector observed two residents knitting, one resident completing a jigsaw and two residents painting. There was an obvious and familiar connection noted between staff and residents. During a group exercise, the inspector observed a staff member actively encouraging all residents to partake. The staff holding the session was aware of the physical ability of each resident in attendance. For example; some residents were encouraged to bend and touch their knees whereas other residents were encouraged to bend and touch their toes. The inspector observed that the residents who attended the session enjoyed the activity and the inspector observed plenty of laughter and chatting.

Activities outside of the communal rooms were minimal. While there was an activities person on duty five days a week, this staff member was allocated to the main communal room. This meant that there was little to no provision of one to one activites for any resident who remained in their bedroom. Activities were discussed at resident meetings, the minutes highlighted that residents were looking for more variety. A small number of residents told the inspector that their only source of entertainment was watching the television. When asked if they would attend group activities, the residents spoken with felt they would if there was a more varied timetable.

Throughout the two days, residents were observed moving freely around the centre, interacting with each other and staff. The inspector observed that personal care and grooming was attended to a good standard. When chatting with residents, the inspector noted that the residents referred to the staff by name. Residents were very familiar with the team that were supporting them. This familiarity with the care staff positively impacted on the lived experience of residents in the centre.

Residents were seen moving about the centre accessing the internal gardens throughout the two days. In addition, staff were observed sitting outside with residents having a chat. The front door of the centre was locked and to exit the centre the majority of residents, regardless of their level of capacity, are required to

get the assistance of a staff member to unlock the door using a four digit code. This code is not freely given to any persons outside of the staff. A small number of residents told the inspector that they felt is was an unnecessary restriction. The inspector asked three staff members for the code and was told on each occasion that only staff can have the code. This restraint is automatically applied to each resident. This restriction, and the rationale for its implementation, was not appropriately risk rated.

The centre was visibly clean. Resident bedrooms were personalised and made to have a homely feel. For example; a resident who had a keen interest in reading had extra bookshelves erected to allow for their books to be on display and within easy reach. While the inspector observed multiple bedrooms were in need of painting, it was acknowledged that there was a programme of painting and refurbishment underway. At the time of inspection, five bedrooms had been repainted and new furniture had been fitted. The bedrooms had been completed to a high standard. A review of the screening in double bedrooms was required as the current screening did not ensure privacy. On the day of inspection, the call bell system in place was being upgraded to a new system.

Friends and families were facilitated to visit residents, and the inspector observed visits occurring throughout the two days.

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

Capacity and capability

This was a risk inspection carried out by an inspector of social services to monitor compliance with the Heath Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). This unannounced risk inspection took place over two days. There were 50 residents accommodated in the centre on the day of the inspection and three vacancies.

The inspector found that this was a well-managed centre where residents were supported and facilitated to have a good quality of life. The inspector followed up on the last inspection findings from March 2022 and found that the provider had made good progress with non-compliance found at that time. Staffing numbers had stabilised and the inspector found this had a direct positive impact on the direct care given to residents. Nothwithstanding the positive findings, the inspector found that the management of residents care who presented with responsive behaviours did not meet with regulatory requirements, and that the systems in place to monitor incidents and accidents was inadequate.

Mowlam Healthcare Services Unlimited Company is the provider of this centre. There

was a clearly defined management structure in place with identified lines of authority and accountability. The director of nursing, who was the person in charge, facilitated this inspection. They demonstrated an understanding of their role and responsibility and were a visible presence in the centre. They were supported in this role by an assistant director of nursing and a full complement of staff including nursing and care staff, activities, housekeeping, catering, administrative and maintenance staff. Management support was also provided by a Regional Manager from the Mowlam Healthcare Group.

The governance and management of the designated centre was well organised and the centre was well resourced. On the day of the inspection, there were sufficient numbers of suitably qualified staff available to support residents' assessed needs. The team providing direct care to residents consisted of two registered nurse on duty at all times and a team of healthcare assistants.

Staff files reviewed contained all of the information required under Schedule 2 of the regulations. All new staff go through a process of induction into the centre. The inspector was told that the induction process was completed over a two week period and can be extended out if additional support is required. The documentation to support this induction process was completed on all files reviewed. Staff had access to education and training appropriate to their role. This included infection prevention and control training, fire safety, manual handling and safeguarding training. Staff responses to questions asked displayed a good level of knowledge.

There was evidence of weekly and monthly governance and management meetings. The quality and safety of care delivered to residents was monitored through a range of clinical and operational audits. The audits included reviews of care planning documentation, incidents involving residents, and wound management. However, the detail contained in the audits did not provide assurances that oversight was in place with regard to the high level of incidents and accidents that had occurred. There was insufficient oversight or analyses of incidents. The inspector reviewed completed incident forms. Incidents involving residents that had resulted in harm were closed out prior to investigation or gathering of information that could inform decisions on how to minimise the potential of further incidents. The provider had failed to identify areas for improvement or develop any quality improvement plans. In addition, the inspector found an incident that had occurred in the centre that was not notified to the Chief Inspector, as required by the regulations.

Regulation 15: Staffing

There was sufficient staff on duty with appropriate skill mix to meet the needs of all residents, taking into account the size and layout of the designated centre.

Judgment: Compliant

Regulation 16: Training and staff development

The provider was committed to providing ongoing training to staff. On the day of inspection, staff were appropriately trained. Staff responses to questions asked were detailed and displayed a good level of knowledge.

Judgment: Compliant

Regulation 23: Governance and management

The management systems in place to ensure that the service was safe and effectively monitored was not fully effective. This is evidenced by;

- Poor oversight of the documentation of adverse incidents. There was a high number of resident falls reported in the centre. Incident forms were poorly detailed and closed out before they were properly investigated. This meant that learning from any incident was not identified.
- Poor oversight of the care of residents with complex needs, including responsive behaviours. Records reviewed reflected delayed interventions that resulted in distress to fellow residents.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A review of the incident record found that a resident had sustained a serious injury. This incident had not been submitted to the Chief Inspector, as required by the regulations.

Judgment: Substantially compliant

Quality and safety

The inspector found that the interactions between residents and staff was kind and respectful throughout the inspection. Residents expressed satisfaction with the direct care received. A small number of residents expressed concern on how incidents of responsive behaviours were managed and told the inspector this caused them concern. Further action is required by the provider to ensure that the centre

comes into compliance with Regulation 5; Individual assessment and care plan, Regulation 7; Managing behaviour that is challenging and Regulation 9; Residents' Rights.

A sample of residents' files were reviewed by the inspector. Residents' care plans and daily nursing notes were recorded through an electronic record system. The inspector found evidence that residents' care plans were developed within 48 hours following admission to the centre to guide the care to be provided to residents. However, some of the completed assessments were not accurate. In addition, care plans had not been updated following an assessment that identified that the needs of a resident had changed. The care plan had not been reviewed and did not reflect the changes in the resident's overall health and social care needs.

Residents were reviewed by a medical practitioner, as required or requested. Referral systems were in place to ensure residents had timely access to health and social care professionals for additional professional expertise. There was evidence that recommendations made by professionals had been implemented to ensure best outcome for residents.

The inspector reviewed wound management practices and found clear evidence that interventions taken had ensured the healing of wounds.

The inspector found that the management systems in place to support residents with responsive behaviours did not meet regulation requirements. The inspector found that timely and appropriate intervention management steps taken at the time of initial escalation of behaviours had not ensured resident safety. A small number of residents told the inspector that as a direct result of recent incidents they sometimes feared for their safety and the staff ability to protect them from injury.

The centre was found to have unnecessary restrictions in place that were not in line with the centre's restrictive practice policy. The standard practice that the front door is locked with only staff having access to the code does not promote a restraint-free environment in line with the centre's policy. While the inspector acknowledged that the use of bedrails was minimal, a review of other forms of restraint, such as front door locks, was required.

Residents had access to advocacy services and information regarding their rights. The inspector spoke with multiple visitors who confirmed that there were no restrictions in place with visiting their loved ones.

Overall, the building was found to be clean. Cleaning staff were knowledgeable on the cleaning system in place and were observed to adhere the policy.

The provider had made good progress on fire safety precautions and procedures within the centre. Fire drills were completed that included night time simulated drills to reflect night time conditions. Records documented the scenarios created and how staff responded. Staff spoken with were clear on what action to take in the event of the fire alarm being activated. Appropriate documentation was maintained for yearly checks and servicing of fire equipment. Annual fire training had taken place in 2022.

Non-compliance found on the last inspection, had been addressed.

Regulation 11: Visits

The registered provider had ensured that visiting arrangements were in place and were not restricted.

Judgment: Compliant

Regulation 27: Infection control

Infection Prevention and Control (IPC) measures were in place. Staff had access to appropriate IPC training and all staff had completed this. Good practices were observed with hand hygiene procedures and appropriate use of personal protective equipment.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had systems in place to ensure fire safety precautions and procedures within the centre met with regulation requirements. Fire drills were completed Records documented the scenarios created and how staff responded. Staff spoken with were clear on what action to take in the event of the fire alarm being activated

Judgment: Compliant

Regulation 5: Individual assessment and care plan

The inspector reviewed care plan documentation in place and found that some care plans did not meet with regulation requirements and required review. For example;

- Nutritional assessments were completed using incorrect measurements. This meant that the risk assessment was not an accurate reflection of the residents actual needs. This was adjusted on the day of inspection.
- Clinical assessments of need for residents at high risk of oral cavity breakdown were not completed at frequent intervals to identify the residents needs. Therefore, appropriate monitoring was not in place to minimise risk.

- the care plan of a resident that required full assistance with feeding had a care plan in place advising that the resident was independent with nutritional needs.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had timely access to medical assessments and treatment by their General Practitioners (GP) and the person in charge confirmed that GPs were visiting the centre, as required.

Residents also had access to a range of allied health care professionals such as physiotherapist, occupational therapist, dietitian, speech and language therapy, tissue viability nurse, psychiatry of old age and palliative care.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The inspector found incidents whereby residents that had presented with responsive behaviours were not appropriately managed. A review of the records of incidents of responsive behaviours found that care was not given in line with the resident's own care plan. In addition, care plans were not updated following incidents of responsive behaviours.

Judgment: Not compliant

Regulation 9: Residents' rights

The provision of activities observed, on the day of inspection, did not ensure that all residents had an opportunity to participate in activities in accordance with their interests and capacities.

There was inadequate privacy screening in one twin bedroom. This is a repeated finding from the March 2022 inspection.

Judgment: Substantially 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	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Moycullen Nursing Home OSV-0000365

Inspection ID: MON-0038588

Date of inspection: 07/03/2023

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The Person in Charge (PIC) and Healthcare Manager (HCM) will conduct a comprehensive review of incidents management; all logged incidents will be reviewed to ensure that the home management team have an awareness of the nature of incidents occurring in the home, to analyse whether there are any trends or patterns emerging, and to provide assurance that the incident records are thorough, fully investigated where required, escalated without delay and accurately recorded. • The PIC will ensure that all nurses completing incidents forms have received training and are aware of how to accurately complete each section and how to conduct a root cause analysis on each incident identified. Where there are deficits identified in the quality of incident records, the PIC will address these with the individual nurse responsible as part of clinical supervision. • The PIC, supported by the ADON, will ensure that each incident is discussed at weekly management meetings and that learning outcomes and service improvements are identified and shared with the team. The PIC will ensure that incident management is a running agenda item for discussion each month at the monthly management meeting and that reflective learning is shared. • The PIC will review the quality of staff education and training in responsive behaviour that is currently delivered to staff to ensure that staff can apply theory to practice and lead to improvements in fostering a culture of safety in the home. We will ensure that all staff are aware of the essential requirements to identify triggers for responsive behaviours, enabling them to intervene appropriately to de-escalate incidents and alleviate any unnecessary distress caused to individual residents and their fellow residents living in the home. • The nursing home staff will use the Incident Escalation Prompt Sheet to support effective, consistent and timely responses to any significant events in the home. • The PIC will regularly review all documented incidents, including falls and will ensure that a Root Cause Analysis is used to assess any increased risk and that the recommendations are implemented and documented in the care plan.	

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• The PIC has notified the incident the Authority of the incident that was highlighted at the time of inspection.
• The PIC will ensure that all recorded incidents are thoroughly reviewed every week to ensure that no potentially notifiable incidents have been inadvertently missed.
• The HCM will monitor compliance with the submission of required notifications to the Authority.
• The HCM, Quality & Safety, will conduct a workshop for staff on resident protection. This will be a practical session, covering Serious Reportable Events and the role of the Mowlam Serious Incident Management Team. The workshop will demonstrate each staff member's roles and responsibilities, including management, in ensuring that all serious injuries are appropriately managed, escalated and notified to the Authority.

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:
• The PIC will ensure that all residents have individualised care plans which take account of all aspects of their physical and mental health, personal and social care needs, and any supports required to meet those needs, as identified by initial and ongoing assessment.
• The PIC and ADON will provide clinical oversight of these assessments and care plans; they will conduct regular clinical documentation audits and reviews to ensure that the residents' care records are person-centred, sufficiently detailed, that they accurately reflect the assessed care needs of each resident and suitably outline the required nursing and care interventions. Where they identify deficits in documentation, they will discuss these with the named nurse as part of regular clinical supervision meetings. A quality improvement plan will be implemented, and this will assist nurses in improving the overall standard of clinical documentation.
• Care plan audits, and associated findings and recommended improvements will be discussed at nursing staff meetings, daily handover/safety pause and at monthly management team meetings.
• The PIC will continue to ensure that care plans will be devised, discussed and implemented in consultation with residents and/or relatives, and that they will be

sufficiently comprehensive to direct care. The PIC will ensure that the nutritional assessments completed are an accurate reflection of resident weights and MUST assessments recorded and will identify the individual risks associated with each resident.
• We will ensure that individual resident's care needs are assessed and appropriate interventions are provided for dental and oral care.

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
• Residents who present with behaviours that challenge will be assessed using an Antecedent, Behaviour and Consequence (ABC) monitoring tool, which will be recorded to analyse patterns of behaviour and to identify the potential triggers for their responsive behaviours, and individual de-escalation techniques.
• A Responsive Behaviour care plan will be drawn up on this basis which will guide staff to provide a consistent and sensitive approach towards each resident.
• The PIC will continue to review the Responsive Behaviour care plans to ensure behavioural triggers are properly identified. These will be discussed with staff. Through reflective practice discussion, individual strategies to de-escalate and prevent further recurrence will be identified and documented.
• The PIC will ensure there is a Multi-Disciplinary approach in the management of all residents with behaviours that challenge.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The PIC will ensure that a varied and interesting activities schedule will be developed in consultation with residents, that will include group activities and one-to-one activities, in accordance with each individual resident's preferences.
• The Social Care Practitioner (SCP) and Activities Coordinators have met with residents and discussed individual activity preferences, and they are reflected in their social, emotional and psychological careplans.
• The PIC and Facilities Manager will conduct a review of all multi-occupancy rooms This review will ensure that both occupants of each twin room can exit or enter the room without adversely impacting on the other occupant's space or privacy; and that privacy screening arrangements are appropriate to maintain full privacy and dignity of each occupant.
• We will review the restrictive practices in the home and will reduce restrictions in the

interests of resident autonomy, based on risk assessment of the environment.

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 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.	Substantially Compliant	Yellow	31/05/2023
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Substantially Compliant	Yellow	31/05/2023
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph	Substantially Compliant	Yellow	31/05/2023

	(3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Not Compliant	Orange	31/05/2023
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	31/05/2023
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	31/05/2023
Regulation 9(3)(b)	A registered provider shall, in	Substantially Compliant	Yellow	31/05/2023

	so far as is reasonably practical, ensure that a resident may undertake personal activities in private.			